BLINDNESS AND THE ELDERLY

HEARING
BEFORE THE
SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES
NINETY-NINTH CONGRESS
FIRST SESSION

APRIL 26, 1985

Printed for the use of the Select Committee on Aging

Comm. Pub. No. 99-519

U.S. GOVERNMENT PRINTING OFFICE
49-558 O WASHINGTON : 1985

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BLINDNESS AND THE ELDERLY

FRIDAY, APRIL 26, 1985

House of Representatives,
Select Committee on Aging,
Washington, DC.

The committee met, pursuant to notice, at 9 a.m., in room 2123, Rayburn House Office Building, the Honorable Edward R. Roybal (chairman of the committee) presiding.

Members Present: Representatives Roybal, Wyden, Jeffords, Wortley, Schneider, and Blaz.

Staff present: Jorge Lambrinos, staff director; Sheila Duffy, professional staff; and John Vihstadt, minority counsel.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

The Chairman. The hearing is called to order.

Good morning, ladies and gentlemen. As chairman of the Select Committee on Aging, I am pleased to convene today's hearing on the important issue of blindness and its impact on the lives of the elderly. The purpose of this hearing is to examine the needs of this country's estimated 4.5 million seniors who are blind or severely visually impaired.

People who lose vision often lose a great deal more than their sight. Vision loss, especially after a lifetime of visual accuity, has a profound effect on the quality of life for many elderly. Without appropriate training and assistance these individuals become vulnerable to further disabilities from falls or injuries, and ultimately become a higher risk for premature institutionalization.

As the elderly population increases, the need for services will continue to grow as well. If the portion of the elderly population with visual impairments remains the same as today, an additional 4.5 million individuals will be in need for specialized services by the year 2020.

The few existing model programs have clearly demonstrated that it is possible to train senior citizens who are blind or visually impaired to live independently in spite of their loss of vision. Many techniques exist that enable blind persons to travel, read, write, cook, identify money and accomplish virtually all other daily activities.

According to several national organizations representing blind and disabled persons funding for title VII, part C—independent services for the older blind, as authorized under the Rehabilitation Act, would be considered an important step toward meeting the needs of this population.

Although current costs of providing independent living services vary from State to State, there is usually only a one time cost which averages about $500 to $600 per client. Without these services, many of these clients would be placed in nursing homes. Nursing home care, at an average cost of approximately $24,000 per year, is a costly means of serving the older blind and visually impaired.

Of course, many of these individuals have other health problems which require skilled care, but it is very likely that others are being needlessly cared for at great cost. With the cost of long term care as high as it is, clearly we can no longer afford to ignore the needs of this population. And of course, there are human benefits difficult to measure in dollars—the feeling of independence and dignity that individuals possess when they are able to take care of themselves.

Unfortunately, there seems to be a tremendous lack of service delivery to this most deserving segment of our population. With perserverence, hopefully the solution will be well within our grasp.

I welcome our most distinguished witnesses and would thank you in advance for taking the time to be with us here today.

The chair would like to recognize at this time Mr. Ron Wyden.

STATEMENT OF REPRESENTATIVE RON WYDEN

Mr. WYDEN. Thank you very much, Mr. Chairman. I want to congratulate you, for the leadership that you have brought to so many aging issues and in particular, for this hearing, and also for the staff's fine work.

I just have a very brief opening statement, Mr. Chairman.

It gives me great pleasure to be here today to take part in this important hearing, and especially to be able to introduce our first witness, Emma Wycoff. Emma Wycoff is a distinguished advocate of blind and deaf citizens and a resident of South East Portland in my district. I think this committee is going to very much enjoy hearing her views.

Mr. Chairman, I want to introduce her just a bit more formally in a second, but I would like to make a brief comment first about how the administration's budget affects blind Americans.

In this budget, Mr. Chairman, the administration has proposed to cut the free mailing services for blind citizens. This means that organizations for the blind will find it much more difficult to send books and literature and other valuable educational materials to their members. The staff reports to me that the savings for the administration's proposal would be a little bit more than $37 million.

Mr. Chairman, I think it is pretty clear that the people of this country, the people of my State, want Government spending cuts. We have got to cut Government spending for our Nation to have long term economic growth. But the American people did not vote last November to balance the budget by cutting mailing services to blind persons on modest incomes.

I sit on the Energy and Commerce Committee which is investigating the General Dynamics Corp., and I am certain that the total cost of the Mailing Services Program to the blind will be less than the amount of money that the General Dynamics Corp. has overcharged the taxpayers of our Nation.

So I hope we use this hearing to start bringing some fairness to the budget, and I think because of Emma Wycoff's presence here today, that is a little bit more likely to happen.

Mr. Chairman, Emma Wycoff is a lifelong resident of Portland, OR. Her accomplishments can be summed up with a few simple facts. She is 74 years old. She has been deaf since age 2. She has been blind since last year, and she now lives on her own. She has the type of courage and tenacity that all good stories are made of. I think her record tells it all and it is eloquent testimony to the importance of the types of independent living programs that the committee is going to look at today.

As a result of independent care services, Emma Wycoff was able to leave a nursing home where she was staying, and return to her own home, costing the Federal Government far less and vastly improving the quality of her life in the process. Thousands of other seniors like Emma should be able to benefit from these services as well.

My thanks to you again, Mr. Chairman, for holding this hearing. I am very happy that Emma Wycoff, a very distinguished resident of my district, and her translator, could be here today, and we wish Emma Wycoff good fortune in all her advocacy work in the days ahead.

Thank you.

The CHAIRMAN. Thank you, Congressman.

The committee is pleased to welcome this morning Ms. Emma Wycoff. Will you please come to the table before us and take the seat that has your place card, and Dr. Margaret Crofton, will Dr. Crofton also come forward?

Before we start, the chair would like to submit the prepared statement of Mr. Rinaldo, the ranking minority member of this committee, for the hearing record. Hearing no objection, so ordered.

[The prepared statement of Representative Matthew J. Rinaldo follows:]

PREPARED STATEMENT OF REPRESENTATIVE MATTHEW J. RINALDO

Thank you, Mr. Chairman. I commend you for calling this hearing today on blindness and the elderly and want to note that this is the first Aging Committee hearing ever held to examine issues relating to visually impaired older Americans.

70 percent of the visually impaired are over age 65.

Nearly one out of every six Americans over age 65 is blind or severely visually disadvantaged.

In my own State of New Jersey, 41,000 senior citizens have serious visual handicaps or are totally blind, and this figure is expected to jump by over 20 percent in the next decade alone.

I am pleased to note that both the Government and the private sector are doing more than ever before to combat blindness and ensure that visually impaired older Americans are able to live independent and productive lives.

The National Eye Institute is making great strides against glaucoma, cataracts and other eye diseases.

The Rehabilitation Act, the Older Americans Act, the social services block grant, and other Federal funding sources assist the visually impaired elderly.

Optometry schools, civic groups, such as the Lions Club, and other private organizations foster prevention through vision screenings.

The Architectural Barriers Act requires most public buildings to be barrier-free and accessible to the handicapped.

But quite frankly, Mr. Chairman, more must be done.

The institutionalization rate for the visually impaired is five times the rate for others. Reliable estimates show that millions in nursing home costs could be saved through small additional expenditures for guide services, transportation, and instruction in daily living skills for the visually impaired elderly.

I join the chairman in calling for adequate funding for independent living services for the elderly blind under the Rehabilitation Act of 1973.

If the elderly blind need a helping hand, they also return that help ten-fold by aiding others.

I invited a 70-year-old blind woman from my hometown of Union, New Jersey, to testify at a field hearing of this committee in New Jersey last year.

She told the committee that there is nothing she would rather do than her daily volunteer counseling of both the blind and the sighted at a local adult day care center.

New Jersey is a national leader in the development of innovative programs for the blind. And I am delighted that Norma Krajczar, executive director of the New Jersey Commission for the Blind is here today to review the accomplishments of her department.

Thank you, Mr. Chairman.

The CHAIRMAN. I would like to recognize the Congressman from New York, Congressman Wortley.

STATEMENT OF REPRESENTITIVE GEORGE C. WORTLEY

Mr. WORTLEY. Thank you, Mr. Chairman.

I have a brief opening statement. I would like to commend you for calling this hearing today on blindness and the elderly. This hearing is an important step in the process of recognizing the immediate needs of a large and growing segment of the elderly population. It is clear that the needs of the blind elderly and the services currently available to them need to be more widely known both so that we can increase the coordination of currently available services and so that we can explore the needs for changes and improvements.

Mr. Chairman, at this point, I would like to extend Mr. Hammerschmidt's regrets for not being able to attend this hearing. I have a statement from him which I would ask unanimous consent that we insert in the record.

The CHAIRMAN. Without objection, that will be the order.

[The prepared statement of Representative Hammerschmidt follows:]

PREPARED STATEMENT OF REPRESENTATIVE JOHN PAUL HAMMERSCHMIDT

Mr. Chairman, thank you for calling this hearing today to bring attention to the needs of older blind and visually impaired persons.

I'm pleased to have the opportunity to introduce a fellow Arkansan, Bean Hudson, who is here as a witness today. On many occasions I've had the good fortune of being able to call on Bean for her expert knowledge of aging and blindness issues—and have no doubt about her outstanding credentials. In addition to her present position as management project analyst with the Arkansas Department on Aging, she is also the national representative on aging for the National Federation for the Blind, chairperson of the National Committee on the Senior Blind of the National Federation of the Blind, staff member of the Governor's advisory council on aging, coordinator of the Arkansas Silver Haired Legislature, and former delegate to the 1981 White House Conference on Aging. I'm glad that Bean is here today, and know that all of us can benefit from her insights on this important issue.

We know that the segment of our population 65 years of age and over will increase significantly in the next 40 years, and we expect that, barring significant medical breakthroughs, the population of the older blind will increase proportionately. In anticipation of this growth, we must continue to seek ways of ensuring that the older blind are able to live increasingly productive and fulfilling lives. Statistics from the American Foundation for the Blind show that the older blind are institutionalized far more often than are their sighted counterparts. Often, the reasons for institutionalization are not for medical reasons but rather because the older blind have not been taught new skills for performing daily living tasks. We all have heard of the emotional and financial benefits gained from living—and growing older—in one's own home and community. While blindness can present an additional obstacle to the older individual, it is one which (through some of the fine assistance programs provided by many of the groups present today) can be overcome. It seems to me that institutionalization should be a last resort, not an option which comes as a result of lack of proper training.

As with sighted older persons, there are often programs available to assist the older blind that they may not know about. While many good vocational rehabilitation programs have been of great benefit to younger blind perons, unfortunately, only those individuals with an employment goal are eligible for vocational services. Thus, even though blind older persons can be trained to accomplish almost all activities required for daily living, under the Rehabilitation Act of 1973, they are not eligible for such training. I hope that we can examine some of the accessibility problems that blind older persons face, and come up with ways to help them to further utilize already existing programs. Then, we will be able to know what programmatic changes are required, and how the Federal Government, State governments, and the private sector can work together to improve programs for the older blind.

The CHAIRMAN. At this point I would like to introduce for the record the briefing paper prepared for the committee. Hearing no objections, so ordered.

[The briefing paper submitted by Chairman Roybal follows:]

BRIEFING FOR BLINDNESS AND AGING

(By Edward R. Roybal, Chairman)

PURPOSE FOR HEARING

The purpose of this hearing is to examine the older blind population, their service needs, and capabilities. The Committee is interested in identifying program and research initiative capable of promoting greater independent in the lives of this population.

THE PROBLEM—A BRIEF ANALYSIS

Nearly one out of every six Americans age 65 or older is blind or severely visually impaired—a group totaling approximately 4.5 million (National Eye Institute, 1985). Some of these individuals have no useful vision, while others have partial vision. The majority of them cannot see well enough to read a newspaper even with the help of glasses.

According to the National Society to Prevent Blindness, it is estimated that 47,000 individuals become blind each year in the United States. Of the five major causes of blindness and severe visual impairment, senile macular degeneration (maculopathy), cataract, glaucoma, diabetic retinopathy, and optic nerve arophy, four are age related.

People who lose vision often lose a great deal more than their sight. Vision loss, especially after a lifetime of visual acuity, has a profound affect on the quality of life for many older Americans. Without appropriate training and assistance these individuals become limited in their ability fo function within their own home. It becomes more difficult to take care of themselves or participate within their community. The result is that they become vulnerable to further disabilities from falls or injuries, and ultimately become a higher risk for premature institutionalization. In testimony presented at a Senate committee hearing it was estimated that at least eighty-five percent of all injuries sustained by persons 65 and older are caused by falls. Twenty-five percent of these injuries are attributable directly to uncorrected visual problems. The American Foundation for the Blind estimates that 15% of the entire blind population are in longterm care facilities compared to 1% of the general population.

It is possible to train senior citizens who are blind or visually impaired to live independently in spite of their loss of vision. Many alternative techniques exist that enable blindpersons to travel, read, write, cook, identify money and accomplish virtually all other activities of daily living (ADL). These techniques are routinely taught successfully to younger blind persons nationwide who receive vocational rehabilitation services. Unfortunately, the elderly population remains virtually unserved by these Rehabilitation programs. This is because only individuals with an employment goal are eligible for vocational services under the Rehabilitation Act of 1973. Since most elderly people are not job bound, they often do not qualify for services.

Under the Older Americans Act, programs for the elderly blind are considered servicable activities. Of Older Americans Act programs, a sampling of three hundred Area Agencies on Aging showed that only three listed a new program initiative targeted for the blind. Also, Social Service Block Grants have a limited capability of providing funding for services to the elderly blind. However, because there are no reporting requirements for Social Service Block Grants, there is no significant data on the numbers of elderly blind that are currently receiving any assistance from those program dollars. The fact that there is so little information available on Social Service Block Grant and Older Americans Act programs for the blind is part of the problem. The senior blind and visually impaired simply are not getting the attention or priority their needs and numbers dictate.

THE POPULATION IN NEED

As the elderly population increases, the need for these services will continue to grow as well. The U.S. Census Bureau projects that the population age 65 and older will increase by 100% between 1980 and the year 2020, compared to an increase of only 21% for the population under age 65. If the portion of the elderly population with visual impairments remains the same as today, this will translate into an additional 4.5 million individuals in need of specialized services by the year 2020. Existing programs are certainly not equipped to meet current demand, let alone keep up with the needs of this burgeoning population.

More than half of the new cases of blindness each year involve a person age 65 and older. To be considered legally blind, a person must either be completely blind, have no better than 20/200 vision with the help of corrective lenses or have a visual field restriction of 20 degree or less.

The estimated 4.5 million seniors that could potentially benefit from services include both those who are legally blind and those with severe visual impairments. The second group, those with severe visual impairments, are not legally blind but have experienced a loss of vision severe enough to interfere with daily living. The definition of severe visual impairment used by the National Center for Health Statistics is the inability to read a newspaper even with the help of glasses.

SERVICE NEEDS: OUTREACH AND TRAINING

The need for outreach services is tremendous. Many seniors have eye disorders such as glaucoma or diabetes that are progressive. Many of the conditions that effect vision go undetected because there is often no pain or immediate vision impairment. Vision loss, as with hearing loss, is usually gradual and not perceived until severe or complete loss of function occurs.

An important aspect of outreach is education. Far too many seniors and health care professionals are unaware of the few services available for persons with vision problems. This has become a problem which is further compounded by the lack of referrals between health care and social service providers. For example, according to two researchers at the Aging Health Policy Center of the University of California, San Francisco, post-surgical patients and others with low vision problems may wrongfully assume that they have received all the treatment and services available from vision specialists (i.e. opthalmologists, optometrists). If they are not given information about retraining at the time of diagnosis and/or treatment, they many never learn of programs and services available to help them adapt to their vision impairment. According to the American Foundation for the Blind, there is an estimated average of 5 to 7 years from the date of notification of vision loss before seniors receive assistance.

Model programs have clearly demonstrated that the blind and visually impaired greatly benefit from training in adaptive skills that enable them to live independently. These skills include:

1. Orientation and Mobility: traveling safely and confidently in familiar and unfamiliar environments using a cane and residual senses.
2. Communication: braille, handwriting, typewriting, use of large print and tape recorders.

3. Activities of Daily Living: meal preparation, identifying money, identifying clothing, telling time, maintaining a household.
4. Low Vision Services: use of low vision aids such as magnifiers to perform near (reading) and distance (mobility) tasks.
5. Peer Support Counseling: interaction among older visually impaired peers to help adjust emotionally to the loss of vision.

CURRENT SERVICES FOR THE OLDER BLIND AND VISUALLY IMPAIRED—SCOPE AND LIMITATIONS

The major provider of the services listed above are state vocational rehabilitation agencies working with the blind, which are funded under the Rehabilitation Act of 1973. However, most senior citizens with visual impariments are not eligible for these services, which are intended to assist disabled persons to find employment. Eligibility criteria are:

1. The individual must have a disability that interferes with employment.
2. The individual must have a vocational goal.
3. The services received must result in the likelihood of employment.

Recognizing that these eligibility requirements exclude many disabled individuals, the federal government amended its regulations under this act to include "homemaker" as a vocational goal. According to the law, if the disability interferes with the ability of the individuals to care for themselves, they may receive rehabilitation services. Even with this adjustment, large numbers of individuals still cannot adequately be served. Individuals who are not heads of households still do not qualify for services. And those who technically qualify may not receive the specialized training they require in independent living skills since the primary focus of these agencies remains vocational rehabilitation. These resources are particularly inadequate considering the large number of elderly in need of services.

Another provider of these services are independent living centers, also funded through the Rehabilitation Act of 1973. The Independent Living Services Program was originally authorized as part of the 1978 amendments to the Rehabilitation Act, and was designed to enhance the independence of persons who are too severely disabled to qualify for vocational rehabilitation services. Since the program was first initiated, only Part B has received funding which has resulted in the establishment and operation of 157 partially or federally funded model independent living centers. Current funding of this program is $22 million.

Part B centers are designed to provide models to demonstrate how a variety of services to individuals with severe disabilities can be combined effectively for the purposes of avoiding costly institutionalization. Funds are awarded on a competitive basis directly to State rehabilitiation agencies, local public agencies or private nonprofit organizations. Unfortunately, the funding for such centers has been far from adequate. Only 14 of these agencies specialize in services for the blind. The remaining agencies serve all disabled groups. While these other agencies in some cases serve the blind as well, they may lack staff specializing in training of alternative skills for the blind. Moreover, it is uncertain whether this funding will be continued in the future.

Congress authorized Part A to create a mechanism to provide independent living services to a broad population of severely disabled persons. Part A was intended to be the source for long-term funding for independent living centers. Through a formula grant program, authorized in contrast to the competitive grants awarded under Part B, these services were intended to be provided in a way which would complement Part B centers, and enable States to effectively utilize the expertise developed through Part B programs on a statewide basis. Until FY 1985, Part A had never been funded. Current funding of this program is $5 million.

Title VII Part C of the same act was authorized to provide independent living services specifically to blind persons age 55 and older. Such services include: outreach and visual screening; the provision of eyeglasses and other visual aids; services and equipment to assist older blind individuals to become more mobile and better able to care for themselves; mobility training, Braille instruction, equipment; and guide services reader services, and transportation services. Estimates for funding by advocates of this program have varied from $2 to $12 million. However, the Part C program has never received funding.

Another shortcoming of present services, both those provided by vocational rehabilitation agencies and by the few independent living centers, is that services for the blind are not always available to the visually impaired. In some cases, the visually impaired may be considered ineligible, while in others they may be technically eligible but considered a lower priority than those who are legally blind. Outreach programs, for example, may be aimed toward the blind community rather than other referral sources more likely to be in contact with the visually impaired.

BENEFITS OF FUNDING SPECIFIC PROGRAMS FOR THE OLDER BLIND AND VISUALLY IMPAIRED

Older Americans Act programs (specifically those provided under Title III B-supportive services and Title IV-research, training and demonstrations) could be able to help provide specific services to the older blind population, if given enough funds to do so. However, it is well documented that Older Americans Act dollars are already having great difficulting in supporting current service levels. Social Service Block Grants could also help fund such initiatives. However, the block grant system provides no guarantee that such services would be provided, and history has shown us that programs for the elderly blind are not able to successfully compete for limited Social Service Block Grant dollars.

According to several national organizations representing blind and disabled persons, funding for Title VII Part C of Rehabilititation Act would be considered an important step toward meeting the needs of this population. Funds could be used either to set up new independent living programs for seniors or to enhance existing services.

Funding rehabilitation services for the elderly could result in enormous cost savings to society. It is estimated that on the average Medicaid picks up 50 percent of all nursing home costs. For example, in FY 1985 the federal government will spend an estimated $14 billion for Medicaid alone.

Current costs of providing independent living services vary from State to State. However, this one time cost only averages about $500 to $600 per client. Without these services, many of these clients may be placed in nursing homes. Nursing home care, at an average cost of approximately $24,000 per year, is a costly means of serving the older blind and visually impaired. Of course, many of these individuals have other health problems which require skilled care, but it is very likely that others are being needlessly cared for at great cost.

It is clear that we cannot afford to ignore the needs of these 4.5 million blind and severely visually impaired older Americans. It is far more cost effective to teach someone to take care of themselves than to take care of them. And of course this kind of training would offer human benefits difficult to measure in dollars—the feeling of independence and dignity that individuals possess when they are taking care of themselves.

Mr. **WORTLEY**. Mr. Hammerschmidt particularly regrets missing this hearing because he will be missing the testimony of "Bean" Hudson, someone whom he respects and admires. I would like to take a second to read what Mr. Hammerschmidt says about Mrs. Hudson in his statement. I quote:

> On many occasions I have had the good fortune of being able to call on Bean for her expert knowledge of aging and blindness issues. And have no doubt about her outstanding credentials. In addition to her present position as management project analyist with the Arkansas Department of Aging, she is also a National Representative on Aging for the National Federation of the Blind, Chairperson of the National Committee on Senior Blind of the National Federation of the Blind, a staff member of the Governor's Advisory Council on Aging, Coordinator of the Arkansas Silver Haired Legislature and former delegate to the 1981 White House Conference on Aging.
>
> I am glad that Bean is here today and I know that all of us can benefit from her insights on this important subject.

I, too, extend my own welcome to Mrs. Hudson and to the other witnesses, and I look forward to their testimony.

The **CHAIRMAN**. Thank you, Congressman Wortley.

The chair now recognizes Ms. Emma Wycoff. Will you please proceed in any manner you may desire.

PANEL ONE: CONSISTING OF EMMA WYCOFF, PORTLAND, OR; AND DR. MARGARET CROFTON, RETIRED PHYSICIAN, HOUSTON, TX

STATEMENT OF EMMA WYCOFF

Ms. **Wycoff** [through interpreter]. We are lucky to have such an organization as the Commission for the Blind. It gives money to old blind people and people who are visually impaired. We need money to give better services.

I will be 74 years old in July. I lost my hearing to spinal meningitis when I was 2 years old. It has also caused my hearing to deteriorate. I became fully blind 1 year ago. I lived in an apartment for many years, then in 1980 I became sick and my vision deteriorated so I went to a care center for 2 years. Then I left the care center because there wasn't enough privacy and means of communications.

The services that I got were abacus, braille, cooking, mobility and typing. Now I am on my own. I have my own privacy and independence. I do my own cooking and my own housework. I spend a lot of my time reading braille books and that I enjoy very much. I also enjoy writing letters and my independent life now.

[The prepared statement of Emma Wycoff follows:]

Prepared Statement of Emma Wycoff, Portland, OR

My name is Emma Wycoff. I am able to live on my own thanks to services I have received from the Oregon Commission for the Blind. I will be 74 years old in July, and I am both deaf and blind. I lost my hearing when I was two and have had increasingly poor vision all my life. Last year I became totally blind.

I went to live in a residential care center when I was 68 because my loss of vision made it more and more difficult to take care of myself. But I didn't like it there. I had no freedom or privacy. I wanted to leave, but my vision had grown even worse, and I didn't think I could manage.

Then three years ago I contacted the Oregon Commission for the Blind. They taught me skills so I could live on my own. I learned braille, cooking, typing, math, and travel skills.

Within nine months I was able to move to my own apartment. Its given me privacy and independence. I do my own cooking and cleaning. I write letters, and I spend a lot of time reading braille books. I enjoy it very much.

We are lucky to have organizations like the Commission and Volunteer Braille Services in Portland. More money is needed so that elderly blind people in other areas of the country can receive the same help I did.

The **Chairman**. Is there anything else?

If not, may I ask then a question. It is my understanding that you had an interesting conversation with Senator Hatfield yesterday, the chairman of the Senate Committee on Appropriations. Would you like to share with the committee what you said to the the Senator when he told you that he was our friend?

Ms. **Wycoff**. I don't remember what I said.

Mr. **Wyden**. Mr. Chairman.

The **Chairman**. Yes.

Mr. **Wyden**. I thank the gentleman for yielding. Emma didn't you say that your friends in Congress ought to make sure that blind services get funded?

Ms. **Wycoff**. Yes sir, I think that now I remember what I said.

The **Chairman**. Mr. Wyden.

Mr. **Wyden**. I am very proud to have a constituent like Emma. It takes a very special sort of courage to do what she has done.

Emma, what would your life be like without the independent care services?

Ms. WYCOFF. Nothing. I would have nothing. Maybe they would put me back in a care center, or a nursing home, I just don't know.

Mr. WYDEN. I just want to say that this Congress can't let that happen, and because of all the good work you are doing, it is less likely to happen, and I am just glad you are here with us.

Thank you, Mr. Chairman.

The CHAIRMAN. Congressman Wortley.

Mr. WORTLEY. Ms. Wycoff, you don't know how proud you make all of us here today when you come all the way from Oregon to Washington and testify before the U.S. Congress on the needs of the blind, the elderly.

I wonder if you might tell us how old you were when you lost your vision and had to learn how to make those new adjustments in life?

Ms. WYCOFF. How old was I? I have never seen well all of my life, but last year I became totally blind. So all my life. I grew up with being visually impaired.

Mr. WORTLEY. All your life you were visually impaired. How did you get your training your basic training? Through your family or a formal education process that assisted you in developing your skills and your ability to communicate?

Ms. WYCOFF. I just was an expert from practicing, I guess. I practiced a lot for myself and I learned myself.

Mr. WORTLEY. Well, you are just very persistent and have faith in God. I guess that is what helps all of us, and I want to thank you so much for coming here and sharing your experience with us.

I yield back the balance of my time, Mr. Chairman.

The CHAIRMAN. Thank you, Congressman Wortley.

May I again thank Ms. Emma Wycoff for her testimony and assure her that as a member of another committee I sit on, the Committee on Appropriations, and the subcommittee that deals with the appropriations of money for the blind, that committee has already decided not to permit the reduction that is being recommended by the administration.

I thank you very much for being present with us today.

The chair now recognizes Dr. Crofton.

STATEMENT OF MARGARET CROFTON, M.D.

Dr. CROFTON. Thank you, members of the House of Representatives and ladies and gentlemen. I want to express my gratitude for being here today and state that I feel rather emminently qualified to speak about the blind because not only am I a physician but I worked, I served as medical officer for 5 years in a county home in which there were aged and blind, so I have a couple of aspects on the problem.

My own diagnosis of blindness, started 25 years ago, and has been progressive since then. I have had periods when I was visually handicapped but it has grown over the past 25 years. My first diagnosis was cataracts for which I had surgery and for a couple of years that was reasonably successful. But 2 years after that I had a detached retina in the right eye which produced a diminution of vision, and 5 years after that I had a second detached retina in the same eye which resulted, of course, in additonal loss.

I thought at that time that I was about through with that sort of thing, but then the question of glaucoma came up and I began to lose peripheral vision in both eyes, and about 4 years ago the diagnosis of macular degeneration was made which resulted in the loss of central vision, and has gotten my reading. Also, I don't recognize people very well because I can't distinguish their features that would let me recognize them. So my problem has been progressive for the last 25 years and sometimes I am grateful for that because I have had a slow adjustment rather than a very abrupt one.

I failed to mention in the beginning that I will be 81 in June, so I belong in the classification of the elderly blind.

In September 1983, I found myself rather abruptly put into a nursing home for a medical problem which would subside with a little care, and I also found out that it was intended that I stay there. This leads me to a discussion of the emotional effect of such a situation. I became depressed, and I think that essentially physicians are not supposed to get depressed about anything, but I was, and the one thing that I can think of about a nursing home is the saying "abandon all hope ye who enter here." That is what I found in the nursing home. It is remunerative to them to keep people there, in the first place, so that they have no reason for improving or helping them to improve their situation, either physical or mental.

As soon as I began to get better, which I did fairly promptly, everybody that I saw who came in to see me, I would promptly state, I don't belong here. It was pretty evident that I didn't belong there. The majority of the patients were brain damaged in one way or another. They either had Alzheimer's disease or had strokes, and I had essentially no companionship and nothing in common but everybody that I said, I don't belong here to would look at me fish eyed, with a glassy eyed appearance and get out of the way.

Of course, the longer I stayed, the more desperate I became, but what happened was I had a friend, rather a friend and his wife, who come to see me every year in November, no matter where I am. I see them for a few hours. They came to see me in the latter part of November and I said "I don't belong here," and they agreed that I didn't belong there, and he said, what do you want to do about it?

I said I want to get out. They were from Mississippi, and he said there must be a way. Mississippi has a program to train elderly people to live alone. If Mississippi has one, surely Texas does. Well, he said, I will find out and he lived in Jackson, so he called me in a couple of days and said there is a program in Texas, that what you need to do is get on it. Shall I start the ball rolling? I said, yes.

So that was about the 9th of December, after a few phone calls, which I didn't make, he made, and I suppose to the State Commission for the Blind to begin with—I am not sure about that—but the program director for the elderly from the Lighthouse in Houston came to see me and she asked do you want to be on the program? And I said, yes, right now. I was going to get out before Christmas but I didn't make it.

The Lighthouse was involved in the Christmas programs and things of that sort and they really didn't have time to process me. So she said the 9th of January.

Christmas meant absolutely nothing to me that year. The only thing I was waiting for was the 9th of January, and I was positive if I could get a little training I could get out of that place in a week. I started on the program, as I say, on the 9th of January, with full intentions of telling that nursing home goodbye the first of February.

The first thing I learned was to dial a phone without being able to see it. Now, I don't know whether the Members of Congress know, but the members in the other group do know that the phone company permits you any number of calls to keep up with the numbers that you can't look up. You are not charged for the additional numbers. So that has been a help, although I don't have too many calls to make for local in Houston because I have only been in Houston for 4 years, the last 4 years.

The next thing that I learned was to count money in change so that I could make change when I went into a store, and they also made me a template where I could write checks, which gives me a sense of independence and the freedom so I can handle what belongs to me now and not ask somebody else to do it.

I was put into a group of people who a great many of them had less sight than I had, as far as that was concerned, but I was with a group of common people with a common problem, and there were discussions that were helpful to some of us and probably not so much to others. In other words, I heard a lot about the diet from diabetics because a third of that group were diabetic and they were on insulin and they needed to know how to shop and how to take their insulin and the dangers of their diabetes and they didn't all know it.

I was taught to fix my breakfast and my lunch. The director went out to my apartment with me and marked my stove and marked the refrigerator and the washing machine and dryer so I could run those things by feel instead of visually, and of course, that in addition gave me some sense of independence.

Then she said make a grocery list. That was the hardest thing that I had to do in the whole rehabilitation. I had been so depersonalized in that place that I was living in, I couldn't think what I needed to start out again. I hid it as well as possible and eventually made the grocery list. I only shopped once a week. Whatever I do has to be fairly complete or else I do without the rest of the week.

I made my lunches and I fixed food for breakfast under the supervision of the supervisor, so that she was sure I could function in my own home, and I moved back the 1st of February, 1984, and I have been there ever since.

I do not do my housekeeping. I don't see well enough to know a dust ball when it is there unless it moves. So I have had help, but I have help once a week and she is there 2 or 3 hours. That includes my expenses for outside care.

Someone takes me to the grocery to shop. I don't always find what I want, but they will check my basket and say did you want this or that sort of thing, and sometimes I pick up the wrong item, but that isn't particularly disturbing. So that I have lived alone now for over a year and gotten rid of the cost of the nursing home, which ran around $1,200 a month, and for less than $20 for housekeeping services, $20 a week, I manage quite well, and I am certainly much happier than I was in the nursing home.

So I have not only saved the money but there is rarely a day that goes by that I don't thank the good Lord for being where I am and being able to do what I want to do as I please, which of course I didn't have in the nursing home.

The CHAIRMAN. Dr. Crofton——

Dr. CROFTON. Yes.

The CHAIRMAN. I wanted to ask a question at that particular point because you are making reference to your change from a nursing home to a completely independent atmosphere.

Dr. CROFTON. Yes.

The CHAIRMAN. And then you are telling the committee that that independence has made a great deal of difference in your life?

Dr. CROFTON. Yes.

The CHAIRMAN. Now, from a physician's point of view, what recommendations would you make to the health care and medical industry to ensure that doctors are made aware of not only the existence but the importance of rehabilitation training?

Dr. CROFTON. That is a very profound question and it is one that I don't have the answer to. It disturbs me as a physician—I have thought about it a great deal in trying to make an explanation of why I didn't know what to do.

The CHAIRMAN. Should it be available in the schools of medicine, in the internship programs?

Dr. CROFTON. I finished medical school in 1942, so there are a lot of things in medical school now that were not available then, but I think training should be made available.

The CHAIRMAN. I agree, so the physicians that will be practicing in the future will completely understand the situation.

Mr. Wortley.

Mr. WORTLEY. Dr. Crofton, I am Congressman Wortley, and I feel somewhat of an extra relationship to you because you are a physician and you indicated that in your semiretirement you worked at the health center at one of the universities down in Alabama. I have a son who is also a physician, he is the college physician at a little college called Alfred University in southwestern New York State. What was your specialty in Pennsylvania?

Dr. CROFTON. I had my residency at Cleveland Clinic in Ohio in internal medicine.

Mr. WORTLEY. And in all your experience in medical school, your internship, or in clinics, you never found any training to instruct the physicians, ophthalmologists, or family practitioners, or internists, in how to handle the care of the blind. They diagnosed the problem but they were unable to cope with some of the human needs that came from that problem. Is this a correct analysis?

Dr. CROFTON. That is correct, and I think there is some explanation for it. It has only been in the last few years that the ophthalmologists can say with reasonable assurance, that you will have a good result. It is very recently that the ophthalmologists have been inserting a contact lens into the eye when they do cataract surgery. Surgery has advanced tremendously but although I had a rotating internship, I believe very few internships have anything that includes the specialty of ophthalmology.

Mr. Wortley. You were at one of the finest medical institutions in the Nation—Cleveland Clinic—for your residency?

Dr. Crofton. That is right.

Mr. Wortley. You indicated that you were referred to the Lighthouse in Houston where you received some of your training in coping with your own needs after blindness. Did you have to pay for that or does the Lighthouse provide that as a service?

Dr. Crofton. The Lighthouse provides it as a service so that I only had to get there.

Mr. Wortley. Now, how do they derive their funds? Is there any Federal funding involved there that you are aware of? Is that usually through the United Way sources?

Dr. Crofton. I am sure there are both but there, of course, there is concern of the Federal funding and I am personally concerned about the discussion which I heard although I am not sure about it, the talking books were to be discontinued except for those that could pay for them, pay for the postage on them.

I want to say that I would not be considered poor but I would have a hard time paying and getting those things back and forth to the post office if it was left up to me to pay for it, and I am sure that there are a great many people who are blind that could not afford them at all, and I hope nobody does anything to the talking books. I read from 200 to 250 a year.

Mr. Wortley. All the more reason why we must keep the post office subsidized to provide a low rate of postage for the blind and the others who need the value of the books in their lonely hours.

I thank you very much, Dr. Crofton, for coming here today and sharing your experience with us. It has been very enriching and has improved the knowledge of this committee a great deal.

Dr. Crofton. Thank you.

The Chairman. Doctor, the Chair would like to thank you for your testimony.

Dr. Crofton. Thank you.

[The prepared statement of Dr. Crofton follows:]

Prepared Statement of Dr. Margaret Crofton

I, Dr. Margaret Crofton, a retired physician, submit the following written testimony to the United States Select Committee on Aging.

As a retired physician, I have witnessed the problems of the elderly from both the professional and personal standpoint. It is my firm belief that the elderly, particularly the elderly blind, are being placed within a microcosm of society, when they are perfectly capable of functioning within the entire structure.

On September 9, 1983, I entered this microcosm. I was put in a nursing home—an experience I consider to be the most horrible of my life. I was put there because I was losing my sight and my doctor didn't know what else to do with me.

He turned my case over to the hospital's Social Service Department and then severed all ties with me—he did not deal with patients in nursing homes. I was left alone.

My doctor never made mention of the programs available to rehabilitate the visually impaired or any of the aids and devices currently on the market, which enable the blind to carry out daily living skills. If he had, I could have been spared the five months of frustration, anger, and depersonalization I experienced while in the nursing home—not to mention the $1,200 a month it cost to live there.

I knew from the moment I walked through those doors of the nursing home that I didn't belong there. And every day I was there, that belief grew stronger and stronger. Even my friends who came to visit me asked why I was there. "This is no place for you," they would say.

As a retired member of the medical profession, I was outraged at the negligence of my doctors. I have had visual problems since 1960 and no one ever mentioned the rehabilitative training that exists for the blind and visually impaired. I'm not just referring to a visual problem that gradually worsened over the years. I have had several major complications--bilateral cataracts, the removal of two retinal detachments, macular degeneration, and glaucoma. I dealt with many accomplished ophthalmologists.

I find it so incredibly hard to believe that with all the services available for the blind, that no one knew of them or took the time to tell me of them. No one.

The medical society simply closed its doors on me and said they couldn't help. All I needed was a referral. And after spending five months in a nursing home, a referral was what I finally got.

It came from a friend who lives in Mississippi. He was familiar with the services for the blind in his state and was sure Texas had a similar program, which they did.

Upon my friend's recommendation, I contacted The Lighthouse of Houston in December of 1983 and began receiving services from their Multi-Care Center for the elderly. Services which literally changed my life.

I was taught basic life skills. How to dial a telephone, count change and fold money, use a cane and travel about, do my own cooking and laundry, and shop for groceries. I was given a template, which enables me to fill out my own checks. And I became part of a discussion group, in which we talked about safety, nutrition and diets, and other pertinent information.

The Lighthouse has given me back my freedom and may independence. I am once again a responsible adult, making my own decisions and living my own life. Losing one's sight is not the end of one's existence. You simply need to relearn how to do basic tasks with a few adaptations.

The three weeks I spent in training at the Lighthouse are probably the three most important weeks of my life. Without the assistance of the Lighthouse staff and their fine programs. I would still be in that nursing home. It is my understanding from the President of the Lighthouse that the direct cost associated with my rehabilitation would be a total of $996.

I am grateful to be in my own home again. Yet, I wonder how many other elderly people with a vision loss are trapped within the walls of a nursing home, when they too could be in their own home living a full and independent life.

The Chairman. The Chair will recognize the second panel, composed of Dr. Carl Kupfer, Mrs. Mary Janet Hudson, Brian Charlson, and John Crews.

I might point out at this point that Congressman Tommy Robinson is unable to be here, but he wishes to welcome Mary Janet Hudson, who is a constituent. He states in his testimony that he has reviewed the testimony, as well as that of the other distinguished members of the panels and is very much impressed with both the information and the practical solutions that they are recommending.

The Chairman. The Chair recognizes Dr. Carl Kupfer.

PANEL TWO: CONSISTING OF CARL KUPFER, M.D., DIRECTOR, NATIONAL EYE INSTITUTE, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES; MARY JANET HUDSON, ARKANSAS DEPARTMENT ON AGING; BRIAN CHARLESON, MEMBER, BOARD OF DIRECTORS, AMERICAN COUNCIL OF THE BLIND; AND JOHN CREWS, PROGRAM MANAGER, SENIOR BLIND PROGRAM, AND THE SOUTHEASTERN MICHIGAN CENTER FOR INDEPENDENT LIVING

STATEMENT OF CARL KUPFER, M.D.

Dr. Kupfer. Thank you, Mr. Chairman.

I am Carl Kupfer, M.D., Director of the National Eye Institute of the National Institutes of Health. I am pleased to appear before you today to discuss visual disorders associated with aging and advances in the diagnosis, treatment, and prevention of these eye problems.

A great many eye disorders are associated with aging. As a result of advances made in other medical fields, people today are living longer and are healthier, yet visual problems keep many from fully enjoying the benefits of their longevity. In fact, age related eye diseases are creating a public health problem of staggering dimensions, one which is comparable in extent and severity to many of those we find in the developing countries of the world.

Let me give you an example that illustrates this point:

Some years ago a blinding disease called onchocerciasis, which is transmitted by flies, was going unchecked in certain West African countries. In some villages as many as 10 percent of the people were blind from this disease. This rate of visual loss was considered so appalling that several African governments, the World Bank, and the World Health Organization joined together to mount an onchoceriasis control program that has now achieved considerable success.

If a disease that was causing a 10-percent blindness rate could trigger this sort of response, how should we react to the diseases that are causing a 16.5-percent rate of severe visual impairment among our own older people? For it is estimated that 16.5-percent of Americans age 65 or over have severe visual impairment; and more than half of all new cases of blindness occur among people in this age group.

Aging related eye disease are responsible for a major portion of the $16 billion that disorders of the visual system cost our society each year. And if research does not provide some answers, this situation could become even worse in the future, because more people than ever before are moving into the the brackets where blinding disease is most likely to strike. The number of Americans age 55 and over could triple by the early years of the next century. It is estimated that this could mean an overall increase of 160 percent in the prevalence of the eye diseases that are responsible for most cases of blindness among the elderly.

At the National Eye Institute we are intensely aware of the burden and the threat that these age-related eye diseases represent. As the Federal agency responsible for supporting and conducting research on disorders of the eye and vision, we have made the conquest of these disorders a high priority in our program. Our job, as we see it, is to make sure that the concepts and tools of the ongoing scientific revolution are used to develop new methods of the diagnosis, treatment, and prevention of the eye disease that threaten so many people.

NEI supported research on cataract furnishes an excellent example of the potential benefits to be derived from studies aimed at prevention of age-related eye disease. At present, cataract necessitates more than 700,000 eye operations a year in this country. The condition is believed to affect about 5 million people, and that figure may rise to 10 million by the end of the century unless adequate preventive measures are found.

Lately, laboratory studies have begun to yield signs that suggest prevention may be a real possibility rather than a distant dream.

For example, NEI scientists are making great progress in understanding how oxidation—a chemical process that occurs in the lens of the eye and in all other tissues—contributes to the development of cataract. With the benefit of these special chemical clues, and others that will emerge from continued research, scientists and pharmaceutical firms may well be able to design drugs that will prevent or slow the development of cataract.

The implications of this would be enormous. If the need for cataract surgery can be delayed by only 10 years per patient, this would mean that 300,000 fewer cataract operations could be performed each year, for an annual savings of $465 million in health costs.

Equal or greater benefits may eventually be derived from NEI supported research aimed at learning how to prevent age related macular degeneration—the leading cause of blindness among older Americans.

Also receiving particular emphasis in our program are studies aimed at the prevention of glaucoma, an insidious, sight impairing disease that now affects 1.5 to 2 million people, almost all of them middle aged or older, and many of them black.

In addition, we are supporting a considerable amount of research on diabetic retinopathy, a potentially blinding disorder that is present in half of the Nation's 10 million diabetics, and develops in 90 percent of all those who have had diabetes 20 years or longer.

Along with fostering research for the preservation of sight, there is another special priority for the NEI. That is to encourage and support studies on visual impairment and its rehabilitation. We would like to make certain that the formidable capabilities of vision research are used to benefit people with severe visual impairment. In particular, research is needed to find ways of helping them to make the best use of their remaining vision. Because 70 percent of these people are 65 or older, we know that any advances we can foster in low vision research will benefit older Americns and help to reduce the burden that visual loss imposes on so many of them. Of course, the NEI cooperates with the National Institute on Aging in this and other areas of mutual interest. In this way, we seek to make sure that age related eye disease will recieve the full amount of attention that the National Institutes of Health is able to give.

Through the research the NEI is now supporting, and later studies and developments based on its findings, it should be possible to counteract the upward trend in the prevalence of these potentially blinding, age related eye diseases, and lessen the handicaps borne by those who have lost vision to them. If this can be achieved, then the value of vision research as an investment will be demonstrated more dramatically than ever before.

Mr. Chairman, that concludes my testimony. I would be pleased to respond to questions from members of the committee.

The CHAIRMAN. Thank you, Doctor.

The Chair will recognize Mrs. Mary Janet Hudson. Will you proceed?

STATEMENT OF MARY JANET HUDSON

Mrs. HUDSON. Thank you, Mr. Chairman.

I would first of all like to thank the House Select Committee on Aging for this opportunity to speak. I now especially would like to thank Congressman Hammerschmidt and Congressman Robinson for their remarks about me and my presentation. I certainly hope I can live up to their expectations.

I speak to you today as a blind woman who is pleased to have this opportunity to talk to you about the need for services for older blind people.

As I said, I have been a consumer of the kinds of services we are talking about today which helped me to function independently and to have a career and a family and carry out my life as I do.

Had I become blind 40 years later than the time I did, perhaps I would have been denied those services, because I might not have had a vocational potential to enable me to receive those services.

I am a member of the National Federation of the Blind and the Committee for the Senior Blind. Through this committee I have gotten personal stories of people who have as we have heard previously been put into nursing homes because well-meaning family members and physicians thought that was the appropriate place for them to be, and found that placement a ready alternative to the learning of independent living techniques.

Our organization tries to make sure that the services that consumers receive are of good quality and foster the first-class citizenship of those that receive them.

In services for older blind people, I think we must first have some services to react to, and, hopefully, a hearing such as this will bring that about. Through my work with the Arkansas Office on Aging and Adult Services, I have gotten a perspective of the need for preventing premature institutionalization, and in the instance of visually impaired people hopefully that can take place through the availability of alternative services and independent living programs.

As you have just heard, the need among older people is very great. The incidence of visual-impairment is growing as the aging population of the country is growing.

Our aging population in Arkansas is approaching 20 percent of the total population being 60 and over. We are second in the Nation.

There are some 20,000 or more visually impaired older people in the State of Arkansas. With the stereotypes these people carry about the abilities of the blind—they grew up in a time when blind people were not as self-sufficient as we are today, and did not have the confidence we have today. When you take that stereotype and the well-meaning family members, it is not hard to predict the consequences of that person's life.

In the State of Arkansas, we are one of less than 10 States in the country which are able to tap into title XX moneys of the Social Security Act for services to older blind people. At that we are still only reaching about 7 percent of the legally blind people in the State of Arkansas and not touching the 15,000 others who have severe visual impairment.

The aging network is set up so that a planning process takes place among area agencies on aging and the counties in the State of Arkansas. The moneys are divided up based on the most pressing needs of older people. When you are dealing with a low incidence population such as the visually impaired, it is easy to see that aging network funds are not the resource that can be tapped to provide services to older people.

There are several points and paradoxes about services to older blind people. The first one I alluded to, the skills that you need to live independently do not change because of your age. Those are necessary regardless of your vocational potential. They are important because of your loss of vision and not your age.

Another thing is that there are programs available to help people who are facing the loss of physical motion through stroke or heart attack or whatever, through insurance programs, Medicare, Medicaid. We are talking physical therapy, occupational therapy. There is nothing similar for persons facing vision loss.

Another point is that there are programs in our State and in other States which provide personal care and services in the homes of older people. We might find instances where we are providing personal care and chore services to people who would be able to do those things for themselves had they had available to them on a short-term basis the services of independent living skills.

Lastly, I would like to say—as something of a paradox—we have heard about the library services. This is something available regardless of your age, also. I think this says to older people it is OK for you to sit and read, but we are not making available to you the services that will also make you independent.

So I urge you to think carefully about the need for these services and do all you can to make sure the money is appropriated to reach older blind people

The **CHAIRMAN**. Thank you.

Mr. Charlson.

STATEMENT OF BRIAN CHARLSON

Mr. **CHARLSON**. Good morning, Mr. Chairman, and members of the committee. Thank you very much for this opportunity to speak before you as a member of the American Council of the Blind, one of the two largest consumer organizations of blind people. I want to express our gratitude to the members of this committee for their recognition of the needs of older blind Americans, that their needs are real and need to be met, and that it is the responsibility of the Congress to see those needs are met.

It was in the Journal of Visual Impairment and Blindness that it was stated in a recent study that rehabilitation agencies are not at present able to provide services to older blind people for three reasons. One, they do not have the time; two, they do not have the staff; and three, they do not have the funding necessary to achieve that.

There are five major functions of life that, as the previous witness explained, are not functions that only exist for those individuals who are of employment age, but rather for all those who are blind and wish to be independent.

The first of those, probably the most important to a real sense of independence, is orientation and mobility. We use systems such as the long white cane that I brought with me this morning, dog guides, and body orientation techniques to achieve that independence and orientation and mobility.

The pleasure, the sense of independence of stepping out of your front door and realizing that that sidewalk can lead anywhere, as long as you have the skills to walk it, is something that is very, very important to every sighted individual, and I think is of even more importance to the blind individual.

Second, elderly blind people need some assistance in living skills. The doctor from Texas has explained how very simple techniques, marking of refrigerators, stoves, washers, dryers, the use of braille or audible recordings in order to label household products, the ability to differentiate between coins in order to make change, the ability to cook one's own meals, both create a great deal of independence and also provide an enjoyable recreation.

I know housewives may disagree with me from time to time about the pleasure of doing some of those things. But I, as a househusband, know there are some rewards to that. Those are not rewards that those same individuals would be able to benefit from had they been institutionalized in nursing homes.

Third, communication skills. I need not tell this committee how important books are, how important it is to be able to read and write in a medium that you feel comfortable with. In many cases that medium might be braille or more likely in the older blind population that medium is recorded matter, whether it be on cassette or on records.

A number of very simple devices have been developed in recent years that will allow a person who is elderly and perhaps suffering some loss of sensation in the extremities and, therefore, cannot use braille, to use these audible devices, such as cards with labels on them similar to the ones you use to ride the metropolitan transit here in the D.C. area, to record labels, to then rubberband canned goods, be able to identify that by running that card through a device that will read it off to you.

These abilities are things that most people don't really understand exist out there. And it is through services such as those that I saw given by the Voluntary Braille Services of Portland, OR, while I was a resident there, that give the older blind Americans an opportunity to take advantage of that new technology.

In addition, many of our elderly citizens who have some visual impairment have residual vision still of some use to them. They may need some counseling and some testing on using low vision aids, such as closed-circuit TV's that will enlarge print to 60 times its original size, change its contrast from black on white to white on black.

They may need to know how to effectively use magnifiers, or special eyeglasses that will allow them to utilize their peripheral vision if their central acuity is not what it used to be.

They also might choose, for reasons of mobility, to use a monocular, which is a single-lens telescopic device that would allow them to read street signs, which are easy for most people to read, but which would allow them with what vision they have left to be independent travelers.

Vision training is something that is simple to discuss at a table such as this, but is not so simple to understand if you are a person with low vision. It takes a person with training, it takes a person with understanding of what kind of success you can have with that kind of training.

The fifth, and I think as a consumer the most important, function that independent living services for elderly blind can provide is peer counseling. Simply the isolation that comes to one when one realizes they are blind or severely visually impaired is one of isolation first and foremost. Isolation can to some degree be resolved through the development of skills such as those I discussed earlier.

But more than that, they can be eliminated, that sense of isolation, through contact with other blind people who have had some success, who have lived through the frustrations, who have developed, through trial and error, some techniques that might be of value to you as a blind person.

I remember numbers of individuals that called in on the toll-free number at the American Council of the Blind national office here in Washington, DC, and we were able to connect them with other older blind people through groups such as Vision, located in Watertown, MA, my new home.

These people get together on a weekly basis to exchange ideas on how to be more successful, exchange recipes, easy to communicate to one another.

Peer counseling is a vital part of all of this training that is required, not only by those my age who are of employment age, but also those who are elderly blind.

We appreciate, as the American Counsel of the Blind, the opportunity to come and tell you about these needs, and hope and trust in your ability as the representatives representing these older blind Americans to do something about it, to provide the funding we need to carry out these programs.

Thank you very much.

[The prepared statement of Mr. Charlson follows:]

PREPARED STATEMENT OF BRIAN CHARLSON, MEMBER, BOARD OF DIRECTORS, AMERICAN COUNCIL OF THE BLIND

I come before you this morning representing one of the two largest consumer organizations of the blind in the nation. We of the American Council of the Blind wish to thank you for your interest in the welfare of older blind persons. Their needs are real and your attendance here today shows that their elected officials recognize these needs.

Before I discuss the types of services needed by older blind Americans to assist them to live more independently, I first will discuss the magnitude of the problem concerning services to this special group of people. As the size of our older population grows, the need for independent living servies for older blind adults will also grow. The United States Bureau of the Census projects that by the year 2000 the number of persons age 65 to 74 will increase by 20 percent and those age 75 and older by 56 percent. We must begin now to prepare for serving this increased population.

Studies suggest that state vocational rehabilitation programs, which are geared to serving younger people to gain the skills needed to obtain employment, are inadequate to serve this population. (Cf. Hill and Harley, "Orientation and Mobility Services for Aged Visually Impaired Persons," Journal of Blindness and Visual Impairment, February, 1984, p. 49.) Many state vocational rehabilitation agencies try to provide service, but they simply lack the time, staff and financial resources to serve this older population. While some senior citizen's centers try to be of service, many blind and visually impaired people will be unable to take advantage of services which they are offered without some basic skills and confidence in their ability to function with impaired vision. Thus, services available to older Americans under the Older Americans Act, such as transporation, may be effectively denied to the older blind person who lacks the necessary orientation and mobility skills required for independent travel. Similarly, a knowledge of braille or other daily living skills may be needed by the older blind American to permit him/her to fully participate in senior citizen center activities.

Given this context what services are needed by elderly blind persons to enable them to enjoy their mature years? There are five primary areas of need which are presently not being met by existing, federally funded programs: orientation and mobility, living skills, communication techniques, low vision training and peer counseling. At present, each of these services are available to the "employable" blind person but they are not available to the older blind person.

Orientation and mobility can take may forms. The long cane, such as the one I use, is the common means of mobility. Dog guides and body orientation techniques are also need. Through the use of these devices and techniques the blind person is able to travel safely from home to work, from church to grocery shopping, from the beauty shop to the doctor. In most cases, the need for mobility is not for employment purposes.

Living skills include all of those skills required for taking care of one's home. It may take the form of money identification, cooking, how to maintain your clothes. In all cases these skills are needed by all blind persons not just those who are of employment age.

Communication techniques such as braille, typing, the use of large print and tape recording equipment, are all essential to the independent blind person. They may need to label spices, cleaning supplies or have access to recorded cookbooks. The two most handicapping aspects of blindness are transportation and communication. Access to the printed word is essential to true independence.

Low vision training is often required by older persons as well as by "employable" blind persons. As many here today will tell you most of those who have a serious sight loss have some usable vision. By usable vision we are not necessarily talking about reading print. In many cases the vision is only useful for traveling, cooking, or reading print that has been magnified through the use of lenses or technology. The training may be in the use of one of these low vision devices or it maybe simply in how to take advantage of the sight you have to cross the street safely.

Peer counseling is often overlooked, but it plays an important part in rehabilitating blind persons. The knowledge that there are others who are having some of the same troubles and frustrations as you are having can help in keeping you motivated. The tips that others can offer you on tasks such as sewing and cleaning take on added significance when told to you by a fellow blind person.

What can Congress do to help provide adequate services to older blind persons? Last year, the American Council of the Blind requested a $2 million appropriation for Title VII Part C of the Rehabilitation Act of 1973 as amended. When Part VII was added to the Rehabilitation Act in 1978, Congress tied funding for this program to funding for Part A of Title VII which authorizes an independent living rehabilitation state grant program. Congress required each state vocational rehabilitation agency to incorporate any new methods and approaches to providing independent living services to older blind people into its independent living program. Thus, the funds for services for older blind people which we are seeking today will not only be used for direct service, but will provide states with experience about efficient, effective methods to deliver these services in their comprehensive statewide independent living state grant program.

In the 1984 amendments to the Rehabilitation Act, Congress separated the authorization for an appropriation for Part C from an appropriation for Part A of Title VII. Each program now has a "such sums" authorization.

In response to our request last year for an appropriation for Title VII Part C, the House Appropriations Committee recommended an appropriation of $1 million for this program because "the Committee is concerned that the needs of elderly blind are not being adequately addressed because the current vocational rehabilitation programs tend to concentrate on blind and visually impaired individual of optimum employable age and serve few middle age or older persons." (See House Report 98-911 at page 114.) The Senate Appropriations Committee, although failing to provide funding for Title VII Part C for FY 1985, also expressed concern that the needs of elderly blind Americans were not being adequately met and directed the Rehabilitation Services Administration to include elderly blind persons in its target population of unserved or underserved individuals (see Senate Report 98-544 at page 166.)

The American Council of the Blind will again ask the Congress this year to appropriate funding for Title VII Part C of the Rehabilitation Act. Although $2 million alone cannot meet the needs of our older blind citizens for independent living services, it is a step toward developing better systems for serving these special people. Obviously, we recognize that an appropriation in excess of $2 million is, of course, needed if any meaningful level of service is to be provided to elderly blind persons nationwide.

The services which older blind Americans need are usually provided younger employable individuals who are clients of rehabilitation agencies. We lack only the funding to support the necessary staff and resources which would enable these same services to be provided to older blind citizens.

The American Council of the Blind receives thousands of requests for information about blindness and services which are available to blind and visually impaired people each year. Many of these come from older people who are just facing the prospect of diminishing eyesight. They are often frightened about their vision loss and desperate for assistance. We also know that with the right kind of timely independent living training these older blind people can renew their hope, and return to active participation in their communities.

Thank you for the opportunity to appear before you today. I would be happy to answer any questions that you may have.

The CHAIRMAN. Thank you, Mr. Charlson.

The Chair now recognizes Mr. John Crews.

STATEMENT OF JOHN CREWS

Mr. CREWS. Thank you.

Years ago, Mark Twain remarked all good things come to those that wait and don't die in the meantime. That axiom has pretty much characterized public policy and the rehabilitation of the older blind until today.

I want to tell you about a program of the Michigan Commission for the Blind that is modeled after the Federal title VII part C legislation. Our experiences over the last 5 years are instructive and should provide a glimpse into the national policy issues we are addressing in this hearing, because the clientele, the program design and components, and the impact of these services are in many ways typical of what one might expect in a Title VII Part C Program.

The people we serve are probably typical of what we would expect in a model program. The average age is 74. The oldest referral was 100. Over one-third of our referrals are from people 80 years of age and over.

Fully two-thirds of our referrals are from women, and 82 percent of these women are widowed. Most clients continue to live in single-family dwellings. While they often experience considerable difficulty reading their own mail, preparing meals, and performing other household tasks, they cling tenaciously to their independence.

We must remember, as we have seen, that this situation is often fragile at best.

Macular degeneration, a central field loss, is the leading cause of blindness among our clients, accounting for 52 percent of our caseload. While an individual rarely becomes totally blind with this condition, an older person is unable to drive, read print, or recognize faces.

It is important to remember that virtually all of these people grew up, reared their families, and worked as sighted people. It is in retirement that they have lost their vision and, therefore, they have not had an opportunity to use resources available to younger, blind individuals.

The core of our program focuses upon providing training in adaptive skills that allow for continued independence that Dr. Crofton described in some detail.

Blindness among the elderly often forces people into isolation because they cannot see faces or travel independently. It is simply easier to stay at home than take the risk of getting out of the house. In response to this need, we have developed peer support programs bringing together older blind people and their families to share in the common experience.

Often these meetings become powerful and cathartic, as blind people and their families reach out from isolation to each other.

Our clients are remarkably strong, resilient, and adaptable, and they can remain independent if they are provided appropriate training and a few adaptive aids.

Two examples will illustrate this point. One of the most remarkable clients that I have worked with was a lady named Anna, 75 years old, widowed, who lived alone. She had only light perception. Her daughter-in-law came once a month to pay her bills, take her shopping, and read her mail. A neighbor stopped by once a week to prepare TV-like dinners that Anna thawed in an electric skillet because she was fearful of using the range.

She never went outside of her home because of the fear of becoming lost or falling. When we began to work with Anna, we sent our mobility instructor to provide an evaluation. And the first thing she asked was: "Would you take me to my basement because I haven't been down there in 3 years."

We taught Anna to safely use the range so she could prepare her own meals. We arranged for a volunteer to take her shopping once a week and requested a telephone reassurance program to check on her each day. With training, Anna was able to walk in her neighborhood and finally to take a bus across town by herself.

The second example is less dramatic, but no less instructive. David had worked for a chemical company and was a truck farmer making a modest living. He was referred to us shortly after he turned 94. David was extremely frail and he could hardly hear. And he did not have enough vision to see the food on his plate.

As a result, his wife spent a considerable amount of time feeding him and yelling in order to communicate the simplest idea. We provided David with a high-intensity floor lamp and a simple low-vision aid that allowed him to feed himself. We also purchased a hearing aid.

As a result of our efforts, modest though they were, David was able to stay at home avoiding institutionalization for 3 years.

Dr. T. Franklin Williams, the Director of the National Institute on Aging, makes a simple but profound observation when he writes:

> A major consideration in the rehabilitative approach to elderly persons is the importance of what may seem to be small gains in function. Such small gains can make all the difference in the degree of independence that a person can achieve in-

cluding the difference between being able to stay in one's own home and requiring care in a long-term care institution.

Dr. Williams uses the example of the ability to transfer. But our examples are equally compelling. We simply cannot underestimate the value of the small gains in the rehabilitation of older, blind people.

We are just beginning to become aware of the profound implications of a nation that is living longer and becoming increasingly disabled. As America ages, increasing numbers of older, blind people will make demands upon social systems and the family structure.

We believe that in Michigan our rehabilitation model has made a steady and measurable impact upon our clients' lives. We also believe that this program serves as an example of what we can do as a nation to preserve the independence and dignity of this country's older blind citizens.

Thank you very much.

[The prepared statement of Mr. Crews follows:]

Prepared Statement of John E. Crews, Program Manager, Southeastern Michigan Center for Independent Living and the Michigan Commission for the Blind

Years ago, Mark Twain remarked, "All good things come to them that . . . and don't die in the meantime." That axiom pretty much characterized public policy and the rehabilitation of the older blind until today.

In the presentations that you have heard this morning, three powerful themes will be reiterated to you: (1) the number of older blind citizens will be increasing dramatically in the coming decades, (2) rehabilitation services for older blind people can make a real, sometimes profound, difference in their ability to live independently and (3) serving older blind people has positive benefit-cost implications.

Today, I want to tell you about a Michigan program that is modeled on the Federal Title VII, Part C legislation. Our experience over five years are perhaps instructive, and I think provide a glimpse into what Title VII, Part C, funded programs would look like as well as some insight into national policy directions.

In 1979, the Michigan legislation appropriated funds to establish the Senior Blind Program as a new program component of the Michigan Commission for the Blind. State legislation mandated that services be provided to older blind people in their home community to allow them to remain as independent as possible. Legislators and advocates understood that older blind people had rehabilitative needs that differ from the traditional vocational rehabilitation model that had successfully guided public policy in recent decades. The Senior Blind Program was established in Saginaw, Michigan, and serves a five county area and that has distinct urban and rural characteristics. The project was designed as a field program in which services are largely provided in the client's home.

CLIENT CHARACTERISTICS

The people served by the Senior Blind Program are probably typical of what one would expect in a Title VII, Part C, model program. The average age of clients at referral is 74; ages ranges are from 55 to 100. Over one-third of referrals are 80 years of age or older. Fully two-thirds of the people served by the program are women; and 82 percent of these women are widowed. Most clients continue to live in single family dwellings, and while they no longer drive, and while they often have considerable difficulty reading their own mail, preparing meals, and performing other household tasks, they cling tenaciously to their independence. But, we must remember that this is often a fragile situation at best; a fall or a prolonged illness may place this person in jeopardy.

The leading cause of blindness among the clients served by this program is macular degeneration. This condition accounts for 52 percent of the people served in the Senior Blind Program and results in a central field loss. While an individual with macular degeneration rarely becomes totally blind, it becomes impossible to drive a car, read small print, or recognize faces. Glaucoma is the second leading cause of blindness in this program, accounting for nearly 18 percent of the caseload. It is important to remember that about 98 percent of these individuals grew up, reared their families, and worked as sighted people. They have not had an opportunity to avail themselves of services that might have been available in school or in the traditional vocational rehabilitation service model.

The situation of vision loss is compounded by the reality that most of these individuals experience additional disabling conditions association with the aging process. While we know that aging is not a disease process, it does mark a time when individuals are exposed to disease and disability. The American Foundation for the Blind estimates that for those older blind people experiencing additional disabilities, the average number is 2.49. Our experience confirms the AFB data, and hearing, another sensory disability, appears to be the leading reported secondary disability.

SERVICE MODEL

The service components of the Senior Blind Program reflect the influence of the independent living movement and a clear commitment to the worth of our constituency. We are not prescriptive in our rehabilitation approach; our clients have lived successfully for seventy years without us, and it would seem presumptuous to now dictate how people should conduct their lives. In our model, we cooperate with the client to identify specific issues that require resolution. A client may identify the need to get to the grocery store or read personal mail. We then develop a service plan that reflects a mutual responsiblity and commitment.

A central emphasis of our program focuses upon providing training in skills that will allow for greater independence. These skills include training in communication (braille, tape recorders, large print material); daily living activities (telling time, identifying coins and currency, dialing a phone); adaptive cooking skills (the ability to work around the range and oven safely), and orientation and mobility (skills allowing an individual to get around in the environment using a long cane or optical aids).

In addition, we provide considerable attention to work in low vision. Low vision is essentially a discipline that allows a person to use optical aids to enhance residual vision. In our program, for example, interns from Ferris State College of Optometry work directly with our clients in his or her own home to address the specific vision tasks that our client wishes to perform. Often simple adaptations can provide excellent results. For example, by providing additional lighting in a work area or by eliminating glare, a visually impaired individual can function much more successfully. Many times, simple and inexpensive low vision aids allow our clients to perform many important tasks such as reading the telephone directory, reading mail, or setting a thermostat.

The experience of being older and blind frequently becomes an isolating and lonely condition. Because older blind people cannot recognize faces, travel independently or read print, it simply becomes easier to remain at home rather than take the risk to interact with others. In addition, because the prevalence of blindness is relatively low, many older visually impaired people may not even know another person having the same experience. We have, therefore, developed a number of peer support groups to allow older blind individuals and their families to gather together to share their experiences. In many ways, these peer meetings are the most important services we provide.

Moreover, the Senior Blind Program also does a considerable amount of work with our clients who experience hearing impairments. Student interns from Central Michigan University's Hearing Clinic work with clients, again, in their homes to provide training in the use and maintenance of hearing aids.

Finally, we make a concerted effort to serve as an information resource to our constituency. Many times, adapted aids and services are so specialized that a client could never fill a need on his own.

SMALL GAINS

We must be careful, I believe, not to overstate or understate the condition of older blind people. As a group, the people I serve are remarkably strong, resilient, and adaptable. They can often remain independent if they are provided relatively simple training and a few adaptive aids.

Two examples illustrate this point. The most remarkable client that I have worked with was Anna, a 75 year old woman, widowed, who lived alone in a declining neighborhood of Saginaw. She had only light perception. While her son lived in the community, he never came to see her, but her daughter-in-law did come once a month to pay her bills, take her shopping, and read her mail. A neighbor stopped by once a week to prepare TV-like dinners that Anna thawed in an electric skillet because she was fearful of using the range and oven. She never went outside her home because of the fear of becoming lost or falling. When we began working with Anna, we sent our mobility instructor to provide an evaluation, and the first thing she asked was, "Would you take me to the basement because I haven't been down there in three years." We taught Anna to safely use the range and oven so she could prepare her own meals; we arranged for a volunteer to take her shopping once a week, and we requested that a telephone reassurance program check on her each day. With mobility training, Anna was able to walk around her neighborhood and finally, to take a bus across town by herself.

A second example is less dramatic, but no less instructive. David had worked for a chemical company and had fallen from a scaffold in 1943 at age 52; subsequently, he had worked as a truck farmer making a modest living. He was referred to us shortly after he had turned 94. David was extremely frail; he could hardly hear, and he did not have enough vision to see the food on his plate. As a result, his wife, Beatrice, spent a considerable amount of time feeding him and yelling in order to communicate the simplest idea. We provided David with a high intensity floor lamp and a simple spectacle mounted low vision aid that allowed him to feed himself. We purchased a hearing aid to enhance hearing, and we provided a large print clock that allowed him to keep oriented to the time. As a result of our efforts—small though they were—David was able to stay at home until age 97.

These accounts are remarkable because they speak of the courage of our constituency, and these examples also illustrate how very effective a simple service can be. While many of our clients are not desperate, they do have difficulty telling time, detecting a street curb, crossing an intersection, setting a thermostat, or reading a newspaper. Individually, each reach restriction is not great, but the sum places a person at risk. I firmly believe that we often tend to become confused as we draw cause/effect conclusions about a person's ability to live independently. For example, when an adult child visits his older visually impaired parent and finds the house far too warm or far too cold because the thermostat has been turned too far up or down, the adult child may conclude that his parent has lost the capacity to make good judgments. In reality, the parent may simply be unable to see the thermostat to adjust it properly.

Dr. T. Franklin Williams, the director of the National Institute on Aging, makes a simple but profound observation in the introduction to his book, "Rehabilitation in the Aging".[1] He writes, "Another major consideration in the rehabilitation approach to elderly persons is the importance of what may seem to be small gains in function. Such 'small gains' can make all the difference in the degree of independence that a person can achieve, including the difference between being able to stay in one's own home and requiring care in a long-term care institution." Dr. Williams uses the example of the ability to transfer, but our examples are equally compelling. We cannot under-estimate the value of small gains in the rehabilitation of older blind people.

BENEFIT COST

Although little research has been done in addressing the costs and benefits of serving visually impaired older people, some of the available data points to very positive benefit-cost implications. For example, we believe that about 7–10 percent of our caseload would be institutionalized if it were not for our services. With an annual cost of skill care at about $18,000, we can show substantial savings for each year that we delay institutional costs. Moreover, the prevalence of blindness and severe visual impairment among those residing in nursing homes is alarmingly high, representing 15.9 percent of the population. In Michigan, this figure accounts for 8,873 people at an annual cost of at least $159,700,000. Our cost for services range about $1,000 for each client served, and the cost for adaptive aids and appliances including low vision aids, is less than $300 for each rehabilitation.

CONCLUSION

We are just beginning to become aware of the profound implications of a nation that is living longer and becoming increasingly disabled. As America ages, increasing numbers of older blind people will make demands upon social systems and the family structure. We believe that in Michigan our rehabilitation model has had a steady and measurable impact upon our clients' lives. We also believe that this program model serves as an example of what we as a nation can do to preserve the independence and dignity of this county: older blind citizens.

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[1] Williams, T. Franklin, "Rehabilitation in the Elderly," New York: Raven, 1984.

The CHAIRMAN. Thank you. I would like to review some of the very interesting facts that you have made available to the committee, with regard to your program.

Can you give us an idea what the cost benefit of this service is to the older blind?

Mr. CREWS. We haven't done a cost/benefit study in our program, but I can tell you what we know. It costs us about a thousand dollars to serve a client in a year. We also know that 7 to 10 percent of the clients we are serving in all probability are at risk of institutionalization, and would be institutionalized without our services.

There was a fine example in Virginia a few years ago funded by RSA in 1977, that served 42 people at a cost of $186,000. Their cost/benefit study showed that it would have cost $368,000 to provide services to those people without that support program. So in a sense, there is a $2 return for every $1 expended.

There is one other powerful statistic I would like to share. The Bureau of the Census indicates 48.3 percent of all nursing home residents experience some vision problem, and 12.9 percent of those are categorized as having severe visual impairment or total blindness.

Nationlly, of the 1,550,000 people residing in nursing homes, severe visual impairment and total blindness would account for 246,000 people. And it is easy to multiply an estimated average of a years nursing home care at $18,000. I come up with $4.4 billion.

The CHAIRMAN. Will you repeat that?

Mr. CREWS. $4.4 billion. If we could impact upon that by only 1 percent, we could save $44 million in 1 year.

The CHAIRMAN. That is just the savings for the 1 year alone, and over a period of many years, of course, that would be tremendously increased, no doubt, by putting in additional measures that may be able to even save more.

Mr. CREWS. Yes, sir.

The CHAIRMAN. Now, your program is 5 years old. Can you give us an idea what the demand is, or are you finding that you are having problems finding clients?

Mr. CREWS. Our referral rate was four times what we had anticipated in our program. It has remained steady. We do not, in fact, do outreach in our program. Today when a referral comes into our program, a client must wait 6 to 9 months for services from our agency.

The CHAIRMAN. Between 6 and 9 months.

Mr. CREWS. That is right. For people who cannot afford to wait.

The CHAIRMAN. Yes.

Now, Mrs. Hudson, you made reference to social service programs for the elderly. Now, these programs are provided under the Older Americans Act—which provides programs such as nutrition programs, transportation, employment, and the like.

In your opinion, are these programs capable of meeting the needs of the older blind person or severely impaired person?

Ms. HUDSON. No, sir, they are not. As I said, the funding process and the planning process that is required under the Older Americans Act wants us to meet those in greatest need. And when you are talking of a population which is small by comparison to the overall aging population, they are not able to meet those needs. They are not really in the business of that kind of service anyway.

Agencies are already established—those which provide those skills to people who are of vocational age, vocational rehabilitation age. The planning process for aging makes it very difficult for projects which can have a large impact to be developed with aging monies.

I checked with the National Association of State Units on Aging and the National Association of Area Agencies on Aging before this testimony, and within their data base, they were only able to locate one project that was now in place using aging moneys in cooperation with rehabilitation funds to help older blind people.

That is not to say there are not more projects than that in the country. But through our work in our data base, there was only one.

The CHAIRMAN. It is my understanding that you are saying these programs are not designed to meet the need that we are talking about this morning?

Ms. HUDSON. We have limited funds and they are trying to make the greatest impact possible to help prevent institutionalization of older people.

The CHAIRMAN. In your opinion, is the problem the lack of funds?

Ms. HUDSON. I would not say it was the lack of funds in the aging network, because I think that the aging network is pretty much restricted in the kinds of services they provide. It is a lack of funding, I believe, through the existing rehabilitation agencies.

They are already in the business of providing this kind of service. They just need to be available to people who do not have a vocational potential.

The CHAIRMAN. Mr. Charlson, is it reasonable to assume that a person can live independently without training?

Mr. CHARLSON. A very good question. I have never come across an individual in my limited years in dealing with the services for the blind field where a person had trained themselves to be successful in doing the things that I received training for while in the public school system and then later in the rehabilitation system.

Cooking is not something that is easily achieved through trial and error with your eyes closed. Neither are things such as ironing clothes.

The CHAIRMAN. Mr. Charlson, I cannot even cook with my eyes open.

Mr. CHARLSON. If you are ever in Watertown, I can feed you well.

There are techniques that I was shown while preparing myself to go on to college that would allow me to do my own laundering, take care of my own cooking needs, that although I pride myself on being good at those kinds of household activities, I doubt highly that I would have stumbled upon them.

The CHAIRMAN. For a lay person like myself, where would I recommend someone who is in need of that service to start making the necessarily inquiries to get the training that we are talking about?

Mr. CHARLSON. A great deal would depend on the individual in question. If they are an older blind person, then a referral to a rehabilitation agency would be fairly ineffectual. Under those circumstances, we rely primarily on nonprofit corporations, such as voluntary braille services, in Portland, OR, and the Vision Foundation in Watertown, MA, the two that I have some experience with.

In both of those cases, those organizations are working under very low funding in order to achieve what they are trying to achieve. And in many cases they have to rely a great deal on volunteers.

I have volunteered some of my services in Portland to volunteer braille services, and I am presently working through one or two of the different programs in the Vision Foundation in Watertown.

So volunteers who are in many cases blind themselves and have a little bit of experience are picking up some of the slack that there is not funding to hire professionals to achieve.

The CHAIRMAN. Thank you.

Now, Dr. Kupfer, the administration, as far as I can understand, in their budget has made no recommendation for revenue sharing, which is the fund that actually finances mailing services for the blind. I sit on that Subcommittee of the Appropriations Committee. I am the chairman of that subcommittee, and it is my intention to put that money back.

We are going to have a great deal of problems with regard to it. I also sit on another Committee on Appropriations that deals with health research and so forth. And I also see the recommendations for reduction in research, in various disciplines.

Now, your agency, of course, does get money for research. But can you tell the committee what portion of your budget is spent for research directly relating to the aging?

Dr. KUPFER. Yes. Approximately 25 percent of the budget of the National Eye Institute is directly related to problems dealing with age-related blinding eye diseases and probably a total of 60 percent is indirectly related in terms of the basic research that we support.

The CHAIRMAN. Can you give us some examples of research on the problems of special groups within the aging population?

Dr. KUPFER. I think one of the best examples would be the efforts we are making in the aging-related macular degeneration which is a major cause of decreased vision among the elderly.

We have concluded a clinical trial just a year or two ago in which a certain type of macular degeneration has been shown to be benefited by treatment with the laser.

This particular treatment will benefit some 13,000 Americans each year who ordinarily would have gone blind from this condition, and I think it will also have a major economic impact in reducing the costs of blindness.

The CHAIRMAN. What type of planning process does the Institute use to help set priorities as to what to look into, how to devote that money to research?

There are so many problems, it seems to me, that with the lack of funds I would be almost completely at a loss as to where to start.

Dr. KUPFER. Well, sir, we have begun a process of program planning with the first plan being in 1975 and the second in 1978, and then most recently in 1983, the third plan has been developed.

What we do is call in our scientific colleagues from the community to identify not only where the needs for research are, but even more important where the opportunities exist, and matching those opportunities with the need.

We look at where the major causes of blindness are, where we feel we can make some progress, and those become our highest priorities. So that there is a method of determining priorities and then making some assumptions as to how much research activity would be most reasonable in that particular case.

The CHAIRMAN. The truth of the matter is we are not going to forget the elderly blind.

Dr. KUPFER. No, sir, not at all.

The CHAIRMAN. Thank you, Doctor.

Congressman Wortley.

Mr. WORTLEY. Thank you, Mr. Chairman.

Dr. Kupfer, you are a medical doctor?

Dr. KUPFER. Yes.

Mr. WORTLEY. Do you think the profession is adequately trained in eye diseases and adequately informed on community resources which are available to assist the visually impaired elderly?

Dr. KUPFER. Sir, I think that this is becoming a matter of great concern for those who are involved in the training of future ophthalmologists. I think the knowledge of what is available and how to make use of it is increasing very rapidly.

I think we are in a state of great change.

Mr. WORTLEY. You feel there is a thrust now in medical schools and internships to bring to the attention of our young doctors what resources are available to help?

Dr. KUPFER. Yes, sir. I am not answering in my capacity of the National Eye Institute, because that would not come under our jurisdiction. But as a practicing ophthalmologist, I can see this is a major thrust, and an increasing concern upon the part of the practicing ophthalmologists.

Mr. WORTLEY. That is encouraging.

Mrs. Hudson, you work for the Arkansas Office of Aging. But yet you argue that the aging network doesn't have the planning mechanism or the expertise to fill the gaps in service to the elderly blind.

Could you explain why you feel this way about the aging network?

Mrs. HUDSON. Yes. I think, as I said, in Arkansas the Division of Services for the Blind is in the business of providing those services that older blind people need already. They are able to reach, as I said, 7 percent of those who probably need the kind of services we have been talking about today with the title XX program.

I don't want to say the aging network is fragmented, but it is made up of individual providers of services at the local level throughout the country. And, again, I think it is more appropriate for the services to the older blind to be located in an agency already in the business of providing those services to other blind people.

Mr. WORTLEY. We are concerned whether somebody is out there doing something about pulling these services together and making the public aware of what does exist.

Mrs. HUDSON. Right. And that is part of the function of the aging network, is to be an advocate for older people and to make sure that people know what services are out there, and we can help to generate some services as much as possible, also.

Mr. WORTLEY. Do you think we are doing a good enough job on that?

Mrs. HUDSON. I think we can always use some improvement in that area, sir.

Mr. WORTLEY. I am counting on you.

Mrs. HUDSON. Thank you.

Mr. WORTLEY. Mr. Charlson, we all realize that there are limits to public funding. I wish the well was bottomless, but unfortunately, it is not.

What efforts does your council have underway to stimulate the development of private sector, business, volunteer, and charitable resources for the visually handicapped elderly?

Mr. CHARLSON. Congressman, we work on a daily basis with a number of private nonprofit corporations and, in fact, encourage their existence. In Massachusetts alone, I have a registry in braille that takes four volumes just to list those agencies serving the blind in one capacity or another.

One of our major efforts is to try to coordinate those efforts so we are not duplicating effort. Because a great deal of the funding to support these services comes from the members of the local communities, we are very concerned that they not be tapped over and over and over again to provide the same services and a duplication.

Groups such as the Volunteer Braille Services, Vision Foundation, Massachusetts Association for the Blind, depend a great deal to direct mail solicitation. The Revenue Foregone postal subsidies we have been referring to off and on during the course of today included some funds that would allow nonprofit mailers reduced bulk rates in order to do that solicitation.

In other words, take the burden off the taxpayers back and put a little bit more of it on a voluntary basis via these direct mail solicitation programs. If we were to lose that subsidy, that would eliminate one major form of fundraising to provide this through that private sector.

Mr. WORTLEY. You cannot raise all this money using the direct mail. There have to be direct efforts.

Mr. CHARLSON. Yes.

Mr. WORTLEY. I have been in fundraising long enough to know that the direct approach is much, much more effective than using the U.S. Postal Service, which is certainly helpful. I just wondered, again, if you feel there is a lot more that your group can do to assist than you are now doing.

Mr. CHARLSON. I think all organizations that have traditionally served the blind have unfortunately been guilty of looking in the other direction when it came to the older blind. That includes consumer organizations.

I am sure the representative here at the table from the National Federation of the Blind would agree with me that it is a renaissance of interest in the older blind person that brings us to this hearing today and that also makes both of our organizations, places one of its highest priorities in the upcoming years advocating for and as far as we can take it providing services to this population.

Mr. **Wortley**. I think you have a great appeal that exists out there.

What is the trend of your fundraising? Is it up or down?

Mr. **Charlson**. The bulk of our fundraising, at least with the American Council of the Blind, has been through a series of thrift stores throughout the Midwest and Northern States. Unfortunately, some of our revenues have fallen off in the past 2 years.

Mr. **Wortley**. Fallen off? That is not a trend for most charities in this country in the last couple of years.

Mr. **Charlson**. It is, unfortunately, for the form of revenue we chose, which was the thrift store concept. The Goodwill Industries will tell you they, too, have had a falling off of sales at their thrift stores.

We are hoping that we can diversify those fundraising efforts in order to create a little bit more stability in that collecting process.

Mr. **Wortley**. I think actually you have a great emotional appeal, because the need here is so overwhelming and compelling. I think you need more than thrift stores.

Mr. **Charlson**. We have an interesting conflict in the handicapped community in general. Yes; there is a large emotional appeal that we could fall back on. But at the same time we are attempting to gain funding in order to support services such as those we have been describing today.

We are also trying to show the public that we are independent blind people.

Mr. **Wortley**. I commend you for that.

Mr. **Charlson**. About the only way we can do that is to show that we don't need so-called handouts throughout our lifetime in order to achieve that, but can work somewhat toward doing that through other means than strictly charitable acts.

Mr. **Wortley**. I commend you for wanting to keep your dignity. But on the other hand, I think some other opportunities exist for you, and I wish you would take another look at them and see if you cannot improve that fundraising.

Mr. Crews, what links does your office have with the Michigan Office of Services for the Aging? How good a job is that office doing in serving the blind or the visually impaired elderly?

Mr. **Crews**. We have had a considerable amount of dialog, as you might imagine.

Mr. **Wortley**. Could you repeat that again?

Mr. **Crews**. We have had a considerable amount of dialog with the Aging Agency, as you probably can imagine. They are very sympathetic to us. They listen to the statistics that we share. But they do not feel that that aging blindness is a sufficiently high priority that they can serve it given the priorities that they have established.

So, in fact, we have had no luck at all in accessing those funds.

Mr. **Wortley**. In this business of ours, you have to deliver. Is the Michigan Office on Aging delivering in this particular case or not?

Mr. **Crews**. The Commission on Aging is not assisting us in any way in terms of funding. As I indicate, they are sympathetic in terms of looking at long-term issues. We have been successful, I think, to some degree in getting area agencies on aging and local providers more understanding of the services that we do provide, and to some degree becoming sympathetic with the rehabilitative approach, rather than the traditional services the aging community provides, which might be something like Meals on Wheels.

Just to give an example, our approach to the inability to prepare meals would be to go in and teach a client how to prepare his or her own meals, while the aging community might be more comfortable in providing prepared meals to that person.

Mr. WORTLEY. I have utilized all of my time.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Jeffords.

Mr. JEFFORDS. Thank you, Mr. Chairman. I appreciate your calling these hearings. This is an extremely important area.

I am Congressman Jeffords. I have just taken over as the ranking Republican on the full Education and Labor Committee which deals with some of the programs which you are interested in. I have just one area that I would like to discuss, and that is ways in which we can assist independent living.

I would like first to ask Mr. Crews, what is the amount of appropriation which you receive?

Mr. CREWS. The State program that we have in Michigan is funded at $200,000.

Mr. JEFFORDS. So the maximum you can serve then is around——

Mr. CREWS. We only serve a five-county area at this point. We are at capacity in terms of our ability to serve clients. And those people who are referred to us now must be put on a waiting list.

Mr. JEFFORDS. I have two further questions which I suppose you should be asking me rather than me asking you. Under the Rehabilitation Act, there is part C which supposedly provides money for independent living services for older blind individuals.

The argument that we hear is that there is already authority under parts A and B of this act to allow for funding of independent services, and that there is no reason for further funding to assist blind individuals. And yet the testimony here seems to be that part A and part B are not sufficient.

And I wondered, first of all, why in the real world can't some of this money be used more effectively to assist blind people, and second, why have we not been able to get money for part C of the Rehabilitation Act?

Mr. CREWS. I might ask you the same question, as you indicated. And we are asking those same questions. What we have found, for example, in the part B models, is that they by and large exclude large numbers of older blind people.

The part B models, as they are funded, are designed to serve younger people who are not visually impaired, and that is just the history of that legislation. The other reality obviously that we face is that part B funding will soon terminate.

Mr. JEFFORDS. Mrs. Hudson, do you have any comments on that?

Mrs. HUDSON. I think Mr. Crews said it as succinctly as possible. I would have said the same thing.

Mr. JEFFORDS. I would like to know how I can help, or what the blind community ought to do in the appropriations committee to try to make it apparent that we ought to have some funding in part C and what kind of funding that ought to be.

And in order to do that at this particular time, it is important to concentrate on the cost/benefit aspects of part C, which you mentioned. And I am going to take the figures you provided.

If you know of any other studies, or if anyone does, on proof of cost/benefit, this is the only way we can get appropriations for those kinds of things.

Mrs. Hudson, you seem to be one of the few, if any, that has been able to use title XX in this area. Can you tell us, if you don't mind giving away a State secret, how you were able to do that?

Mrs. **Hudson**. I can't give you the history of that. I think we have been quite lucky in Arkansas to be able to use the title XX money for aging. Many other States are not able to do that either.

We have close to $5 million in title XX money in our aging programs. And then close to half a million dollars in the title XX services for the blind.

I think it is that old thing about, "how do you get to Carnegie Hall? Practice," stay at it with the agencies who do have the ability to divide up the title XX money, to make that need known. But as I said, we were able to only find seven States that are utilizing title XX money for services for older blind people; so it must not be a simple thing to accomplish in most States of the country.

Mr. **Jeffords**. I appreciate your testimony very much. Unfortunately, my schedule does not permit me to listen to more than one panel. I do very much appreciate the testimony I have been able to listen to, Mr. Chairman.

I certainly would like to work with you to see what we can do to help in this area.

The **Chairman**. Thank you, Mr. Jeffords. Let it be known in part A of that title, there has been appropriated $5 million, which was actually put in by the Senate, not by the House, and then finally agreed to by the House in conference.

That in part B, the recommendation was for $21 million, and we put in $22 million. This was for fiscal year 1985. And for part C, there was no recommendation from the Senate. However, the committee put in $1 million which was ultimately lost in conference.

This year we are going to look very carefully at part C, particularly after this hearing. We have learned more about it. And at this time we would like to ask for your help in any way possible to see to it this year part C is not taken out.

I wish to thank each and every one of you for your testimony this morning.

Thank you very much.

The **Chairman**. Our next panel will be made up of Jamie Casabianca, Mrs. Norma Krajczar, Mr. John Wilson, and Mr. George Conn.

I am going to ask Ms. Casabianca to start off the discussion.

PANEL THREE: CONSISTING OF JAMIE CASABIANCA, NATIONAL CONSULTANT ON AGING, AMERICAN FOUNDATION FOR THE BLIND; NORMA KRAJCZAR, EXECUTIVE DIRECTOR, NEW JERSEY COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED, STATE DEPARTMENT OF HUMAN SERVICES; JOHN WILSON, PRESIDENT, NATIONAL COUNCIL OF STATE AGENCIES FOR THE BLIND; AND GEORGE CONN, COMMISSIONER, REHABILITATION SERVICES ADMINISTRATION, DEPARTMENT OF EDUCATION

STATEMENT OF JAMIE CASABIANCA

Ms. CASABIANCA. Thank you very much.

Before I get into my testimony, which I will make brief, I would like to respond to a question that has come up twice.

I respectfully differ with Dr. Kupfer in terms of the medical community. It has been my experience in 11 years that the medical community, especially ophthalmologists, do not really have any training in terms of dealing with blindness and there is a study out that shows that there is a 7-year gap between the time somebody is told they are visually impaired and can no longer be helped medically and the time they are referred to any rehibilitation services.

So there is a gap. It may be improving, but at the moment it is pretty bad.

What I am going to talk about today are two things—quality of life in terms of how independent living helps this in the older blind and visually impaired persons, and I am going to talk about what I have found in going around the country in my capacity as national consultant on aging in terms of programs that are out there and existing.

Some of the most important gains that are achieved through independent living services are the intangible ones. Most of the older people that we work with have always been independent, self-sustaining, supporting members of their communities and suddenly they find that they have a vision impairment and they are afraid, very afraid, of losing their independence.

They are worried about becoming dependent on family members and friends. They are also concerned about their place in the community and maintaining their own feeling of dignity and self-worth.

As previous witnesses have testified, there is also an element of fear. People become isolated and may withdraw because they no longer feel that they have something to contribute. In fact, as everyone here is aware, aging does not diminish one's ability to contribute to society. A blind or visually impaired person can help and function as a member in society.

Initially, blindness and vision loss may make the individual very afraid of how he/she will proceed in the future. He/she is afraid of becoming more dependent and of having to be institutionalized as a result of vision loss. He/she may also be afraid of sustaining further physical losses.

An estimated 66 percent of the older visually impaired persons have at least one other impairment. In order for them to remain contributing members of society, independent living services are essential.

At the risk of belaboring the point, I feel that it is extremely important to allow the blind and visually impaired individual the choice between receiving Meals on Wheels or learning how to cook independently.

We tend to take handicapped people and place them in a position where society does for them. This is very bad for self-image. It is very important particularly for an older person to realize they are still vital, they are alive, they can contribute and they have something to give.

Through rehabilitation and independent living services, they can get out on their own and cook for themselves, should they choose to do so.

Again, I believe it is a matter of choice and of involving the older person in the process of choosing what types of rehabilitation services he/she would like to have, what is out there and what is available.

All too often people sit home or are institutionalized simply because they do not have sufficient information. Being older does not mean that one is unable to learn. This "inability to learn" is due to the stereotypes that society has put on older people: If one is old then one cannot learn, one cannot remember, one cannot adjust.

On top of that are the stereotypes concerning blindness, that one is helpless, hopeless, basket weavers, et cetera. I have worked with many old blind and visually impaired people, that have said to me, "We feel that the public should learn more about blindness. They need to be educated."

When I have asked these people, "When you could see, how did you feel about blindness, how interested were you?" They responded they really were not interested. Unfortunately, blindness does not hit until it hits home.

I believe it is very important for us to let people know what is out there and what is available.

In my capacity as National Consultant on Aging, I have been asked to speak at blindness agencies in rural and urban areas throughout the country concerning the establishment of programs for the visually impaired elderly. By and large, the funds in the blindness community are geared to the vocationally oriented individual.

That is not to say funds don't belong there. What I am saying is the older person who has worked all of his life, as a contributing member of society, has an equal right to expect services as does the younger vocationally oriented person.

The programs that are being put in place for older visually impaired and blind people are very haphazard, training is infrequent, and they certainly do not get the kind of quality as does a younger person.

I have also been asked to speak to many professionals in the aging communities. I have attended 10 to 12 conferences this year. I have also talked with staff at area agencies and national State units on aging. They all tell me that they are aware of having a number of visually impaired people in their groups. However, they have no idea how many people there are, and they say it is certainly not a priority to serve this population as of now.

They don't see the need. I think it is very important for us to educate the aging community as to what is out there so that when they find a visually impaired person, they know where to refer him/her and what services are out there for blind people.

I believe it is equally important for both networks, aging and the blindness, to try and work together to pool resources, because, as has been pointed out often, funds are not what they used to be, and money is getting tight. Therefore, it is very important that we each recognize each others expertise.

The existing centers for independent living say that they do serve older blind and visually impaired persons, but in fact the majority do not. They do not have the professional staff with the necessary blindness training and the blindness background. The appropriate professionals to work with this population are rehabilitation teachers, orientation and mobility instructors and low vision specialists.

In the aging community, one will often see professionals and seniors themselves who are afraid and uncomfortable when dealing with older visually impaired people. Upon walking into a senior citizens center, one will often find blind or visually impaired people sitting at a table by themselves simply because the staff and other seniors do not know how to relate to these people.

For all the previously mentioned reasons, I strongly believe that funding for independent living services is essential if we want to keep our older people as contributing members of society and out of institutions. I very strongly feel that this is their right. They have given a lot to society in their lifetime and now have a right to expect something from us.

Thank you.

[The prepared statement of Ms. Casabianca follows:]

PREPARED STATEMENT OF JAMIE CASABIANCA, NATIONAL CONSULTANT ON AGING, AMERICAN FOUNDATION FOR THE BLIND

Mr. Chairman and Members of the Committee, I would like to express my gratitude to Chairman Roybal for inviting me to present Testimony on behalf of the American Foundation for the Blind concerning independent living services for the blind and visually impaired elderly. The American Foundation for the Blind is the national voluntary research and consultant agency in the field of services to blind persons of all ages and has long been concerned about the lack of adequate services to the elderly segment of this population.

In my eleven years of working with the blind and visually impaired, I have come to realize that motivation and opportunity are key factors in learning skills and techniques—not age or disability. I have worked with individuals ranging in age from 55 to 100, and have observed remarkable changes in their feelings of self-worth and dignity once they realize that they do not have to become or remain dependent upon family members or friends, and that they do not have to be placed into nursing homes or other institutions because they have lost their sight.

In most cases, the blind individuals I have worked with are initially uncomfortable in learning skills for coping with their new life situation. They are afraid of failure.

For so many years, society has told older persons that they cannot learn, that their memory is no longer sharp, and that their ability to retain information is poor. On top of this is the stereotypic belief that blind people are helpless, hopeless, and incapable of caring for themselves. Upon being given an opportunity to participate in appropriate rehabilitation training, older blind and visually impaired persons begin to realize that their anxieties and fears have no basis in fact. Once the first skill is mastered, the desire to increase skills, to gain new information, grows rapidly.

Services for independent living specifically designed to meet the needs of the older blind and visually impaired person are extremely important for a number of reasons. As I have already stated, older people are capable of learning and eager to obtain the necessary skills which will keep them functioning as independently as possible for as long as possible within their own community.

There is also a cost benefit to be derived from providing independent living services. The cost of adaptive aids and appliances which help blind and visually impaired individuals in their own homes and within their own communities is minimal. Graduated measuring cups and spoons, large-print or braille timers, large-print or braille clocks and watches, writing guides, canes, etc., are relatively inexpensive. Specially prescribed low vision aids, such as telescopes and magnifiers, and hearing aids, if needed, are more costly. But all of these devices combined do not amount to a fraction of the cost of institutionalization. For the most part, these devices require a one-time outlay of money.

Quality of life is another benefit of independent living services. Given the choice, most individuals prefer to remain independent, self-reliant, participating members in their own community. Placement in nursing homes or other facilities for the aged should be a last resort. Too often, however, such placement occurs only because blind or visually impaired older individuals, their families, and the professionals involved are not aware of other alternatives for dealing with the needs of this population.

Funding for Title VII, Part C, of the Rehabilitation Act of 1973 would partially help to relieve an ever-growing need within this population for independent living services. Although there are many independent living centers throughout the country today, most of them are not designed to meet the specialized needs of the blind and visually impaired older person. Appropriate centers must be staffed with professionals specifically trained in working with the blind and visually impaired. Rehabilitation teachers, orientation and mobility instructors, and low vision specialists are essential for providing specialized rehabilitation training to this population. Peer counseling, social work, group work, and self-help groups geared towards the special needs of newly blinded or visually impaired are also essential in providing quality service.

Despite the fact that most professionals in the blindness and aging systems agree concerning the importance of providing rehabilitation services to the older blind and visually impaired population, there are very few programs in this country which meet this need. In most States, services to the blind and visually impaired are geared to the younger vocationally-oriented individuals. Rehabilitation services to the elderly, when available, are infrequent, poorly staffed, and inadequate. The emphasis of many programs designed for this population is recreational rather than rehabilitative in nature.

Some components which are essential to independent living services for this population are:

1. Qualified, specially trained personnel in the field of blindness.
2. A complete medical work-up, including ophthalmological, low vision, and audiological examinations to determine physical capabilities.
3. A comprehensive evaluation in the areas of rehabilitation teaching, orientation and mobility, and social work, to determine capability and to help the individual cope with and improve limitations.
4. Self-help groups, so that program participants can exchange ideas, problems, thoughts and solutions with each other, and thereby benefit from each other's experiences.
5. Counseling for the purpose of helping the individual to better understand some of the feelings, fears, and anxieties that accompany vision loss.
6. Avocational training to enable the newly visually impaired individual to return to former activities within the community, and to learn new recreational possibilities and opportunities.
7. Advocacy training to teach the individual ways in which to obtain needed services, to restore confidence in the ability to do for one's self, and to assist others experiencing similar problems.

It is very encouraging to me to know that there is a Select Committee on Aging, whose responsibility is to look at the ever-growing needs and problems of the nation's elderly population. Sixty-six percent of the severely visually impaired individuals in this country are over the age of 65. For too long, the needs of the elderly blind and visually impaired have been ignored or pushed aside in favor of the vocationally-oriented individual. It is my firm belief that it is just as important to train blind and visually impaired older persons, so that they can remain independent in their own homes and continue to be contributing members of society as it is to train younger vocationally-oriented individuals for jobs.

In conclusion, Mr. Chairman, we believe that funding of Title VII, Part C, of the Rehabilitation Act of 1973 will help to make independent living services for older blind individuals possible. We appreciated your leadership as a member of the Subcommittee on Labor, Health and Human Services, and Education of the House Committee on Appropriations in obtaining favorable House action last year on an appropriation for this program.

We sincerely hope that you will urge your colleagues to approve an appropriation of $2 million for this program for fiscal year 1986.

The CHAIRMAN. Thank you.

The Chair now recognizes Mrs. Krajczar.

STATEMENT OF NORMA KRAJCZAR

Mrs. KRAJCZAR. Thank you.

Mr. Chairman, members of the committee, ladies and gentlemen, I am Norma Krajczar, executive director of the New Jersey Commission for the Blind and Visually Impaired, a division of the State department of human services.

I am pleased to share with you this morning the results of a needs assessment and strategic planning effort which our agency undertook 2 years ago, as they relate to the services for older blind persons which you are considering at this hearing.

The evidence of these efforts, coupled with our own experience over the past 75 years leaves us no doubt that there are thousands of elderly, visually impaired citizens in New Jersey—and their numbers are escalating dramatically—who need and can benefit from training which will enable them to access the mainstream aging network and thus remain in their own homes and communities. We know beyond question that minimal investment in these services will eliminate the demand for extraordinary expenditures for long-term care and support.

As a blind person myself, and as a former rehabilitation teacher/ now director of one of the country's largest multiservice agencies for the blind, I submit that the needs which can be met through specialized services such as ours are clear and direct; that these services have proven their effectiveness; and that they can result in enormous cost savings to the taxpayer.

They are the needs for outreach and identifcation of older blind people; the provision of vision services which often will restore visual function or prevent further visual loss. They will provide training which will permit the individual to travel independently; to maintain his or her home and personal affairs; and to continue to participate in—yes—and contribute to, family and community in the fashion which was the satisfaction of a lifetime.

It has been said that 37 percent of all persons residing in nursing homes need not be there if community based services were available to them. In New Jersey, the yearly cost of a nursing home bed is $20,000, and 70 percent of all nursing home residents are supported by Medicaid.

Permit me to suggest that an investment in independent living services for 600 older blind persons might well result in a cost savings of $12 million in unnecessary and disruptive institutionalization. In my opinion, this would be money well spent—and desperately needed.

Of equal importance, however, community based independent living services would provide comfort, security, and dignity for those persons who have spent their lives as taxpayers and how now look to their Government for the training which will enable them to remain in their homes and communities during the waning years of their lives.

There is an old adage which says that if you give a man a fish, he will eat for a day, but if you teach him how to fish he can eat for a lifetime. Independent living services are like teaching a man to fish. They are a one-time investment for a lifetime of independence.

On behalf of New Jersey's older blind citizens I am honored to have had the opportunity to speak with you this morning.

Thank you.

The **Chairman**. Thank you very much.

May I state at this point that your Representative from New Jersey, Mr. Rinaldo, is the ranking Republican member of this committee. He asked me to express to you his regrets for not being able to be here and welcome you this morning, but he has asked me to do so on his behalf.

Mrs. **Krajczar**. Thank you.

The **Chairman**. Not only welcome you, but compliment you for a very excellent statement and I will be sure that when Congressman Rinaldo reads the record, that he sees that I did in fact welcome you as he has demanded.

Mrs. **Krajczar**. Thank you so much.

The **Chairman**. You are more than welcome.

May I at this time recognize Mr. Wilson.

STATEMENT OF JOHN WILSON

Mr. **Wilson**. My name is John C. Wilson. I am currently the president of the National Council of State Agencies for the Blind and executive director of the Texas Commission for the Blind.

On behalf of the entire membership of the National Council of State Agencies for the Blind, which represents every agency for the blind in the United States and its territories, thank you for the opportunity of testifying on this important issue.

The bottom line on what you have heard is that no specific funding exists to assist elderly blind persons. What is important to note is that although there are programs available to elderly people in this country, blind people cannot easily access them.

Elderly people have the same needs as other older people, but these needs are compounded by the onset of blindness. Their lack of vision causes them and their families a great deal of fear and confusion about leaving their home environment.

Without sight, they cannot read the public announcements about programs, and they have great difficulty in accessing transportation. In summary, the majority of elderly blind persons are simply unable to go where services are offered to other elderly individuals.

In addition ~~to the new~~ State/Federal independent living service programs, the 1978 amendments to the Rehabilitation Act added discretionary grant programs, including a program under title VII, part C for providing special independent living rehabilitation services to older blind individuals. The purpose was to provide special programs of independent living rehabilitation services to assist in meeting immediate needs of older blind individuals in adjusting to their blindness.

It is our belief as State administrators of blind programs that $12 million would be the minimum necessary to get services for the older blind population off the ground. We would suggest a State matching requirement at some negotiated level. We think that the funds should be allocated to States on a formula based on the 1980 census of older Americans, with some consideration given to population density.

With an appropriation of $12 million, States will be able to provide the services needed to over 20,000 older blind individuals. The funds will allow States to demonstrate the effectiveness of services by enabling this population to maintain independence and dignity and to avoid institutionalization. This will provide Congress with the data verifying cost effectiveness of services delivered.

We are not asking for funds to supplant or duplicate existing good programs. Our goal is a network of services which would, one, allow the elderly blind to access these programs and/or to help the service providers integrate this population into their existing programs and, two, provide the specific adaptive services to compensate for the lack of sight. This population is virtually unserved.

The issue of Federal funding for elderly blind programs is a complicated one. The leveraging of the Federal presence and commitment through funding are needed to gain support at the State and local level. If a State sees that it can bring in additional funds by matching a Federal dollar, it will take the action to do so.

A second phenomenon is that Federal appropriations for a program emphasize the priority placed on it. This principle is manifested clearly in my State where State funds to run programs for the elderly blind have been all but eliminated. Without Federal participation, services will dwindle to almost nonexistence and services will certainly not be available statewide.

As an example of the impact of matching funds, local lighthouses for the blind in Texas have absorbed administrative costs, transportation, and secretarial support in cooperative programming with our agency, which contracted for older blind services with State funds.

I would like to comment for just a moment on Dr. Crofton's testimony. The friend she was talking about from Mississippi did, in fact, call me.

I, in turn, called the president of the Houston Lighthouse, who was operating the cooperative program with the commission and the Lighthouse, and she did access and gain those services and become independent.

I need to report to you that unfortunately, that program will be eliminated on August 31, the end of the State fiscal year. Those were State funds in that program along with Lighthouse funds and not Federal funds because we don't have an appropriation.

The cost effectiveness cannot be overlooked, and it will be important that any regulations on funding be flexible enough to accommodate such cooperative efforts.

Our societal attitudes about aging are complex, and, in my opinion, it seems that children's programs are easier to get funded. The elderly person who suffers a loss of sight becomes forgotten too often by family, community, and society as a whole.

From my point of view as a State administrator watching our own State legislature, it is apparent that the old saying, "People love kittens, but don't like cats" rings true. The tendency is for these vulnerable persons to be given "back seats" in normal life and forced to give up being responsible, contributing members of society.

This isolation from the rest of society cuts the elderly blind person off from a full life as you and I know it, where we have some control over our living situations. When seeking services that would assist, the elderly blind are usually already in a crisis situation that threatens their ability to remain in their homes. These are usually people who have worked all their lives and then find themselves falling through the cracks of service delivery systems.

This morning you have heard numerous witnesses tell you about the serious issue before us. We know, without doubt, that the population of older blind adults will increase dramatically in the coming years; we know, too, that there are great costs involved in ignoring this issue.

We know that independent living rehabilitation can make a difference. It is within your power today to begin to reshape public policy and foster programs that will preserve the independence and dignity of older blind citizens who have contributed so greatly to this Nation.

This is an opportunity we cannot afford to lose.

Mr. Chairman, I have a personal comment I would like to make at this time. On a personal note, from my years of working with the blind, it really becomes increasingly difficult to say no, I can't help you, to this overwhelming population that we are discussing today.

Thank you.

The CHAIRMAN. Thank you, Mr. Wilson.

Mr. George Conn.

STATEMENT OF GEORGE CONN

Mr. CONN. Mr. Chairman, and members of the committee, it is a distinct privilege to appear before the Select Committee on Aging to present testimony regarding rehabilitation programs for elderly and visually disabled persons.

The State-Federal Rehabilitation Program is one of the oldest service programs in the United States, having its origin in the Smith-Fess Act of 1920. Over the past 65 years, the act has been amended several times. However, the Congress has maintained its emphasis on the vocational aspects of rehabilitation throughout the 6½ decades of the act's existence.

In addition, there are two other acts which have significance in this area: one, the Randolph-Sheppard Act, which provides for the establishment of vending facilities operated by blind persons on State and Federal property; and, two, the Javits-Wagner-O'Day Act, which permits the National Industries for the Blind and the

National Industries for the Severely Disabled to bid on product and service contracts with Departments of Federal Government, for example, the Department of Defense and the General Service Administration.

A third program exists in the discretionary grant area within the Rehabilitation Services Administration. This is the $4.2 million support for the Helen Keller Center in New York and five or six other satellite facilities in other countries.

The elderly population, and particularly the disabled elderly, presents a great challenge to health and social service providers. The number of persons over age 65 is currently about 23.5 million or about 11 percent of the total population in the United States. The U.S. Bureau of Census has noted that in 1900, 1 person in 10 was over age 55; in 1982, 1 person in 5 was over age 55; and by the year 2010, it is estimated that 1 person in 4 will be over age 55.

One of RSA's newest priorities is to increase access to rehabilitation and independent living services for elderly blind persons. The reason RSA established these priorities is because the agency raised the issue in the rehabilitation community in 1981 and subsequent years.

These awareness programs, and in-house working group efforts, led to the establishment of the priorities. The intent of the agency is to modify current vocational rehabilitation program practice which tends to concentrate on blind and visually impaired individuals of optimum employable age and serve few middle-age or older blind persons.

The Vocational Rehabilitation Program has served many elderly blind persons especially with the provision of training in homemaking skills and daily living activities. The Rehabilitation Services Administration recommends placing more emphasis on rehabilitation services, including job training and job placement, as well as independent living services.

Our statistics show that older blind persons, aged 55 and over, accounted for 1.3 percent of all persons rehabilitated in fiscal year 1980, 1.5 percent in fiscal year 1981, and 1.6 percent in fiscal year 1982. These statistics show that there is a trend in which more and more older blind persons are being served by vocational rehabilitation.

In 27 States, elderly blind persons receive services through the State vocational rehabilitation agencies; the remaining 33 States have separate agencies serving blind persons exclusively. The Rehabilitation Act of 1973, as amended, included a mandate for the State vocational rehabilitation agencies to give priority to eligible applicants with the most severe handicaps.

Since that act was passed in 1973, the percentage of severely disabled clients, including those who are blind, has risen to nearly 60 percent of the total served. As the average age of our citizens continues to increase, the numbers of elderly blind will increase.

Although employment is not necessarily an issue with these individuals, adjusting to loss of vision and learning to master the problems of daily living can be extremely taxing. The Rehabilitation Services Administration will continue to seek ways to help these individuals to enjoy the retirement years for which they have worked so many years.

Before I conclude, and prepare to answer questions, I would like to let you know that I have had some personal experience in this situation. I have been spinal cord injured for nearly 29 years now and the concomittant loss of renal function due to chronic renal disorders has caused me also to deal with the problem of chronic hypertension, for which I receive medication and which is reasonably controlled.

However, approximately a year ago, I was transporting my daughter out to Madison, WI, to attend the university out there. We had just concluded a lot of activities to prepare here for entering her first year of the college experience.

We were having dinner at a local restaurant when I suddenly saw a pinpoint flash of light in my left eye and immediately thereafter temporarily lost about 35 percent of the vision in my left eye.

I did a number of tests for myself, including holding up my napkin and looking straight at the center of the napkin to try to determine exactly what the symptomology was so I could later report to on ophthalmologist.

I could not drive back to the campus from the restaurant where we were dining, and the experience left an indelible impression on me as to the complexities not only of physical disability, but also the physical stability known as blindness, low vision or visual impairments.

That coupled with multiple stage conditions has been the principle focus of my stewardship as Commissioner of Rehabilitation Services Administration. For 4 years, I have tried to lay emphasis on the importance of carrying out the mandate of the Congress in the primacy of serving severely disabled people as enacted by the Congress in 1973, and also laying emphasis on our need to meet the pressing needs of disabled people who are in need of services along with those who provide the services.

Mr. Chairman, thank you very much for an opportunity to appear before the subcommittee. I will be happy to answer any questions.

The CHAIRMAN. Thank you, Mr. Conn.

Mr. Conn, last year, as you know, the Congress directed RSA to include elderly blind individuals in its targeted population of unserved or underserved individuals and to provide opportunities for independent living services to older Americans through programs funded under the Rehabilitation Act.

Can you tell the committee how RSA has responded to this directive?

Mr. CONN. Yes, sir. An information memo entitled "Vocational Rehabilitation and Independent Living for the Elderly Blind" has been prepared by RSA and will soon be sent to all State vocational rehabilitation agencies or any other entity which wishes to utilize that information.

It points out that one of RSA's newest initiatives is to better serve elderly blind persons.

The number of older and blind persons in our population is growing, as the needs for rehabilitation services—State agencies are being encouraged to develop more rehabilitation services such as job training, job placement, and independent living services for the elderly blind.

I might also say that I am very proud of our agency in that we have led a very concerted effort within the administration to foster a debate on the surge of the cost effectiveness of our program vis-a-vis the budget appropriations which have been requested by the administration in successive years and to which the Congress has responded.

I am proud of RSA in terms of the fact that of all of the Federal programs in the so-called social service area, none has held its funding at a more secure level than has Rehabilitation Services Administration.

We feel that it is perfectly justified by the cost/benefit aspects of that.

The CHAIRMAN. Perhaps you can tell the committee how much funding has been requested by RSA for parts A and B of the Rehabilitation Act for, let's say, fiscal year 1986.

Mr. CONN. Under part A and part B, the total recommended funding would be $21 million.

The CHAIRMAN. $21 million. However, the Congress in 1985, authorized and appropriated $22 million. Why the reduction?

Mr. CONN. Well, I may have to check the figure, Mr. Congressman. It may be that in fact we have requested $22 million.

The CHAIRMAN. All right. Perhaps you can tell the committee what is done with regard to part C. What is your recommendation with regard to part C?

Mr. CONN. We have no recommendation for part C.

The CHAIRMAN. You have made no recommendation for funds under part C?

Mr. CONN. No, sir. We have tried to expand services for elderly blind persons under part B.

The CHAIRMAN. You are expanding those services only under part B.

Mr. CONN. Yes. I think it is important for the committee to understand, Mr. Chairman, that in fact the independent living program grew out of a concerted effort by many physically disabled individuals—I was part of that process in the late sixties and early seventies.

If we look at the history of the rehabilitation program over the years, there are certain evolutionary aspects of the program which are important for any administration or the Congress to consider. Let me give you an example if I could.

Prior to 1943, and the advent of the mass production of penicillin, there was no rehabilitation program for spinal cord individuals because they simply did not survive that particular disabling condition due to secondary infection. That having been corrected almost overnight and the survival and the projected lifespan of that particular disabling condition being a normal lifespan these days due to pharmacological and technical improvements, has led us to expand rehabilitation programs for that.

It may be that it is time for us now to expand the independent living program for elderly blind persons and we are attempting to do that.

The CHAIRMAN. Mr. Conn, the entire hearing this morning I think focused on one thing, and that is independent living, and the possibility of funding C at a level that would at least start the program for the elderly blind.

There seems to be a difference of opinion as to the amount. Mr. Wilson has recommended $12 million, I believe, and Ms. Casabianca said let's at least start with $2 million.

Your recommendation is that we don't fund it at all. What do you think of that, Mr. Wilson? Then I'd like to ask Ms. Casabianca to see what her opinion is.

Mr. **Wilson**. Well, Mr. Chairman, in giving you an answer I would like to come back to the magnitude of this problem, and that is what is so frustrating to State administrators.

The 1.6 percent of all the rehabilitations of older blind persons that was referred to earlier, I believe represents some 3,200 individuals out of a population that could utilize services estimated between 1.5 and 4 million persons. It is so overwhelming it just defies a State agency to even make attempts at services. I would like to reinforce the idea with you that the $12 million I mentioned is in our judgment the minimum that would allow the agencies to demonstrate in a meaningful way to Congress the real cost effectiveness of this program.

I would also like to mention something else, Congressman. A Federal presence will allow State agencies to get the support of local and nonprofit and volunteer efforts in this matter.

I can give you specific examples of that. In the case of the facilities utilized by Dr. Crofton, one of the board members of the Commission for the Blind donates time and money every week to this program by providing transportation and shopping services for the elderly blind.

There is no Federal program, and the State program will be eliminated at the end of this fiscal year.

I believe the president of that Lighthouse is here and I think he would tell you, as many others will, nonprofit organizations many times are reluctant to buy into a program unless there is some stability. Stability comes from a Federal presence.

The **Chairman**. Thank you.

Ms. Casabianca, will you give your opinion?

Ms. **Casabianca**. I think that Mr. Wilson is more competent to talk about $2 million versus $12 million.

What I would like to say, however, as I have said earlier, is that this population by and large is not being served by the centers for independent living that now exist. They do not have the personnel to effectively work with older blind and visually impaired adults, so they are not being served under that program.

What is also happening is that under the so-called homemaker status independent vocational rehabilitation, that varies very much from State to State. It depends. There are rules and regulations but how the rules and regulations are carried out vary from State to State and from counselor to counselor, and in many States you have to be the head of a household, you have to be fairly active.

It does not really cover the people—that, I think, everybody here was talking about your 75, 80, 85 years old, who are often frail, elderly, and need assistance and are not getting it either under the part B or under the homemaker closure status Mr. Conn was talking about.

The CHAIRMAN. I was asking this question because it is my intention to propose the amendment or present the amendment that would fund this C part by at least $2 million. I was seeking, of course, good arguments as to why $2 million was good and now I would like to have more arguments as to why more is even better.

I would like to ask Ms. Krajczar about whether or not reductions in the budget are actually affecting the blind and how.

Ms. KRAJCZAR. I have to constrain myself so I don't talk too much.

Two immediate reactions, Congressman. First of all, I would submit to you that if indeed from a historic perspective services were being quarterly addressed for older blind persons through parts A and B, there would not have been a grounds well of effort to encourage the Congress to include part C in the amendments to the act.

I think the very fact that part C exists recognizes the historic fact that parts A and B, because of their origins and because the groups that pleaded that the Congress include these sections, that those other rehabilitation programs were not meeting the needs of older blind people.

With respect to the amount of money, I must suggest that if an amount of $2 million were to be appropriated, if it were to be spread among the States providing services and areas and districts that are providing services to older blind persons, the amount of money available to anyone of us regardless of the population with which we are dealing, I think would not give us an opportunity to initiate a program that could prove very much to us or to you in terms of cost/benefit.

I think that if we had a $12 million appropriation, appropriated as Mr. Wilson has suggested, then each of us providing services in accordance with the population demand would be able to field a program that could be researched, could be evaluated, and upon which data could be collected that would really give us a handle on what we already know, which is the fact that services of independent living for older blind people are indeed cost effective, that they will prevent people from being institutionalized.

The CHAIRMAN. Thank you.

Now, Mr. Conn, let us just suppose that we were successful in passing the amendment in the subcommittee, and the full committee. Finally, it got to the House and passed the Senate and became law, and that that amendment had, let's assume any figure between $2 million and $12 million.

Could you outline the type of services which could be provided to older blind individuals if Congress were to appropriate that money, or do you believe that there is no need for that money?

Mr. CONN. Well, I do have an answer prepared for that, Mr. Chairman. I would like to preface my remark by saying that if the Congress were to appropriate moneys for part C, I would hope that the Congress would appropriate moneys for part C for elderly disabled persons, period.

The problem that has been outlined for you today by elderly blind persons is a real problem. There is no doubt about that. But so is the problem for elderly persons with schizophrenia, Alzheimer's disease, cardio-pulmonary problems, multiple amputations, multiple sclerosis, spinal cord injury, all of which are now amenable to all sorts of therapy and do provide persons with such problems a reasonably normal lifespan, and I would hope that the Congress would look at the concept of independent living as it has benefited people under parts A and B, and apply that across-the-board to elderly disabled persons.

Now, what would we do with the part C moneys? The grants would be made available on a competitive basis to designated State vocational rehabilitation units to develop special programs of independent living to assist older blind individuals in adjusting to their blindness by becoming better able to care for their individual needs. That is standard practice in any vocational rehabilitation program.

Services provided under such special programs would include services to help correct blindness, the provision of eyeglasses and other visual aids, equipment necessary to assist an older blind individual to become more mobile, mobility training and braille instructions, guide services, reading services and transportation and supportive services or rehabilitation teaching services in areas such as home mechanics, home personnel management, home economics and communications skills.

Among the communication skills that are critically important are the use of telephonic equipment and the burgeoning use of remote actuation, assistive devices and computer assistive devices. We are hard at work right now in Rehabilitation Services Administration and also I am chairman of the Subcommittee on Policy for what is called the General Services Administration Committee on Computer Support for Federally Employed Handicapped persons.

We see that it is critically important in the coming generations of computer development for computer equipment to be totally accessible to physically handicapped individuals. There is a possibility that in the design of the internal architecture of new generations of computers and in software programming that even our best assistive devices will not allow future generations of blind and otherwise disabled individuals to utilize those particular systems which are going to be critically important to not only independent living skills, but any type of job placement skills we might be able to offer through rehabilitation in the future.

The CHAIRMAN. Mr. Conn, I think we are all aware of the fact that title VII, part C, deals with the elderly—blind persons that are 55 years of age and over. What is anticipated is that this funding make available outreach, visual screening, services and equipment to assist older blind individuals to become more mobile and better able to care for themselves.

It also would include mobility training, braille instruction, equipment and so forth, guide services, reader services, transportation services, all under C. At the moment there is no funding being recommended for C. My hypothetical example was that in the event that we were to appropriate that amount of money, anywhere between $2 million and $12 million—and now I rephrase that—will you be able to specifically put in place those services that I have read from this list?

Mr. CONN. Yes. I just more or less repeated the same services. We would make a good faith attempt to do that. And we would urge our State partners to implement that as rapidly as possible.

The CHAIRMAN. But in order to really put in all these services, you don't have a figure as to its cost, do you?

Mr. CONN. No, I do not, sir.

The CHAIRMAN. Would you like to take a guess?

Mr. CONN. No, I would not even hazard a guess, sir. When you get into those type of estimates, it is a very complex problem.

The CHAIRMAN. I, as a layperson, will sit on that committee and make that recommendation. And it is going to be—originally, I thought it was $2 million. Now I have doubts, perhaps it should be more.

However, whatever amount finally survives, it is our hope that it will be a step forward, a step in the right direction so that as time goes on we can improve the situation.

The CHAIRMAN. One thing that we, I think must acknowledge, and that is the great need.

Mr. CONN. Indeed.

The CHAIRMAN. The need is there. I don't think it should differ from the opinion that I have, nor Mr. Wilson, nor Mr. Casabianca. The need is there.

The truth of the matter is that no funding has been recommended. It is going to be difficult to put in any additional amount of money. And that we want to at least get started in the right direction.

Can we agree up to that point?

Mr. CONN. Yes. We have no difference with the committee on that point, Mr. Chairman. I might add that in the past at appropriations hearings we have raised the issue of reprogramming of Federal dollars for such purposes.

We are not convinced within the administration or in the Department or in RSA that there is a need to add additional dollars because we have realized in the past that simply providing dollars does not necessarily best serve disabled people.

On the other hand, if we can reprogram dollars rather than just giving disabled persons a benefit, especially those who are elderly blind, the moneys could be reprogrammed to Rehabilitation Services Administration where we do hands-on rehabilitation at the State and local level—we would endorse such a thing.

The CHAIRMAN. Now, Mr. Wilson, I would like to have your opinion with regard to how these funds can be spent.

Now, I was almost satisfied with at least a start, $2 million. You said, "No, $12 million." How are we going to spend those funds in the next year?

Mr. WILSON. The $12 million, sir; would enable the States to serve, as I stated earlier, something over 20,000 individuals, which represents anywhere from a half to 2 percent of the population we are talking about.

I would like to bring your attention to the scale of this. In my own State of Texas, we have researched this issue to a large degree. And we do know that in our own State, to provide a skeleton of services, statewide, would require at least $1.2 million each year.

So what I am really trying to say, Mr. Chairman, is even at $12 million we are only going to have enough in each State to get the program going and get it off the ground. And I do recommend that each State be mandated to provide services if you were to appropriate those funds, to bring again stability of Federal presence.

I have forgotten your specific question—I am sorry.

The **Chairman**. I think you made it quite clear. You have given me a very correct answer without knowing what the question was.

Now, is there anything that Ms. Krajczar or Ms. Casabianca would like to add in answer to any question?

Mrs. **Krajczar**. I would like to make one observation. I am not sure during this entire morning perhaps we have stressed enough the fact that we are not talking about people who are simply older and blind or visually impaired. That, in fact, over 50 percent of our entire clientelle at the Commission for the Blind and Visually Impaired are multihandicapped. I wish I could tell you what the percentage of our older blind people are who have a secondary and tertiary and even more complicating disabilities beyond that.

So I would suggest to you that when we are talking about older blind people, we are talking in many cases about older blind people with Alzheimers, older blind people with amputations due to diabetes, older blind people with many of the complications of advancing years.

I think that in the case of New Jersey, we would take the moneys given to us and try to stretch them as far as possible, and if it were permitted by regulation through using those as seed moneys to develop a more comprehensive network of services, using whatever community-based resources we could find.

The one, obviously, that comes immediately to mind would be the area offices on aging. At this point, we are attempting to initiate four contracts on a pilot basis with four of those offices which will provide outreach to their community, identification, screening for the purpose of identifying visual impairment, provision of social services, and then full circle back to us for the provision of the kinds of specialized services that those persons might require.

So I would suggest that in our case, if it were possible, that would probably be the kind of planning that—with which we could use this money.

The **Chairman**. Thank you.

Ms. Casabianca.

Ms. **Casabianca**. I would also like to say that everybody, all of my colleagues are specifically with a State. Talking from a more general point of view, since I travel around the country, I think everything they are saying is very valid. And what I have seen in the last couple of years is that services that are traditionally provided through your VR system are being cut back as moneys are cut back, and as funds get tighter.

I think for this reason, since this population is not being served, everything you have heard here would be very good ammunition for you to say, hey, these people are now not getting served—they were being served better, I would say, 10 years ago, maybe 8 years ago.

But within the last 4 years services for this population are being cut back. And that is why we so desperately need the funds go for part C.

The **Chairman**. The Chair recognizes Congressman Blaz.

Mr. **Blaz**. Thank you very much, Mr. Chairman.

I should mention I share with you your concern because on this part C particularly, I have noticed in my reading since it was authorized since 1978 we have never had any funding.

It is kind of distressing a little bit. And I would like to be helpful there when the appropriate time comes.

I have a question for you, Mr. Conn. Your statistics which you cited indicated blind persons aged 55 and above made up only 1.6 percent of those rehabilitated through the rehabilitative services programs in fiscal year 1982.

This is a very, very low figure. I was wondering if you could indicate to us—it indicates to us individuals are not being adequately served by your department, sir. Can you go through the facts as to why this is such a big problem, and what needs to be done to correct this problem?

Mr. **Conn**. I will try, Mr. Blaz.

The history of the rehabilitation program, as I have stated previously, has its primacy in the area of vocational rehabilitation. The Congress has given us a heavy task. We have tried to be very faithful to that task.

Last year, despite the recent economic situation in the United States over the last 3 years, in the area of vocational rehabilitation, which is funded by a billion dollars by the Congress—very generously—we experienced a 4.4 increase in the number of persons rehabilitated, otherwise described as being placed on the job or have been reintegrated in their communities due to independent living services or some other homemaker services.

We feel that is a very impressive figure in light of the fact that employment has been a difficult problem in the United States. It remains that employers throughout the United States have realized that regardless of a person's physical or mental condition in this country, with sound rehabilitation programs, that person can be employed.

When it comes down to determining who should be eligible for such services, because our program is an eligibility program—the Congress has never made it an entitlement program—we go through diagnostic and evaluation determination efforts to determine whether or not a person is feasible for vocational rehabilitation.

This is done at the State level. And if that person is determined to be feasible for vocational rehabilitation, then they are declared eligible and they begin to receive services.

The U.S. Bureau of Labor Statistics and Department of Labor defines the working age in the United States as 16 to 64. It is very difficult for our State partners to work beyond the ages of, let us say, 18 and approximately—somewhere between 55 and 60 years of age, in terms of marketing our human resources product.

Our product is a good one. It is well trained. It is well restored. We can say to employers that we can tell the employer exactly what the qualifications and the characteristics of the individual are, thus raising the comfort level of the employer.

When you get in the higher age ranges of 55 to 60, and a person suffers a disability, albeit a severe disability, and the Congress of the United States has said to the agency, you must focus your attention on vocational rehabilitation, on those of working age, and you must determine that they are feasible for services in terms of their vocational feasibility. And that is what we must concentrate on.

If the Congress wishes to amend its intent, then, of course, we would then comply with the intent of the Congress as we have faithfully with the intent of the act over the years.

That is not to say that we would be reluctant to provide independent living services to blind persons, especially if they are elderly.

Currently, under part B there are 74 grantees. Twelve are administered by either vocational rehabilitation agencies or private, nonprofit organizations serving blind or visually handicapped persons.

In addition, there are five more projects jointly sponsored by both the State general VR agency and the State VR agency serving the visually handicapped. The 57 grantees serving all disability groups within their resources also serve persons who are blind, except where there are specific part B centers for this purpose.

We do not have specific data regarding numbers. However, in California there are 23 centers and recent data show all of these centers are serving the visually handicapped as well as persons with hearing impairments, physical and mental disabilities, and the developmentally disabled.

Mr. Blaz. As I understand you, sir, you are saying that 1.6 percent is not low, and that——

Mr. Conn. It is low. But there is a reason for it being low in that——

Mr. Blaz. You are hampered by Congress.

Mr. Conn. We are limited. We are not hampered. We are limited by virtue of the intent of Congress to ensure that this is primarily a vocational rehabilitation program.

There are other Federal programs which provide benefits to elderly blind persons. We would prefer that the Congress would look very carefully at the possibility of reprogramming dollars from these other areas that provide simply a benefit and do not attempt to rehabilitate people, because we feel our program is one that really changes the lives of people and enhances their potential, to either live independently within the community or being productive members of that community. We do not shirk from that concept at all.

Mr. Blaz. May I ask one more question, sir?

Did you wish to comment on that, Mr. Wilson?

Mr. Wilson. We State directors have a serious concern about reprogramming in a sense that the vocational rehabilitation funding, under section 110, currently is not sufficient to serve all of the people who are eligible for our program.

For example, in my particular agency, with the limitations of section 110 funding, we are forced to, under regulations, establish a priority of service which we call an order of selection, which in essence does deny some persons who are eligible for our services to get them.

So in our case, any reprogramming would simply reduce further the number of visually impaired people that could be served under vocational rehabilitation. So I would ask that serious consideration be given not to reprogram section 110 funds, but to get to the issue at hand which is part C.

Mr. BLAZ. Thank you.

Mr. CONN. May I respond? It is not the intent in our proposal to say that any section 110 money should be reprogrammed. We feel that the dollars there are valuable dollars.

We are talking about other programs that serve disabled people, which do not provide rehabilitation services to them. It provides a benefit to them. But we believe that we can use the dollars much better in a rehabilitation program so that these people can then go back to the community, be reintegrated in the community.

There is nothing more I wanted to do when I was injured in the Air Force in 1957 than to go out into the community and get a job and spend the dollars I earned anyplace I wanted to.

And that is no different than any other disabled person, regardless of the category or degree of disability. We simply want an opportunity to be able to rehabilitate such persons, rather than simply give them a benefit and say, nice folks, read, do homemaker services, go into a nursing home, do whatever, but don't bother us.

We feel that we want to make sure that those people have an opportunity to become full participating members of the community.

Mr. BLAZ. Thank you. Thank you very much, Mr. Conn.

I just have a quick question for Mr. Wilson.

Mr. Wilson, we all know the great State of Texas has a lot of money. You know that the emphasis here in Washington is to have a share and share alike program. I think you could help us a lot if you can tell us what the great State of Texas has been doing to contribute to the efforts of the elderly and the blind.

Mr. WILSON. You have got me today.

Well, sir, until just recently, I think that historically the State of Texas has truly been a leader in the commitment to disabled persons in all categories, and in particular the blind and visually disabled Texans.

The Texas Commission for the Blind is an old agency. There is an old commitment. It has funded more than its share and more of the required money that is under the VR act, for example. But I don't want to waste a lot of your time.

But our economy in Texas is driven to a large degree by oil and gas. I don't really think I have to tell you what has happened to oil prices. Depending on which economist you ask, in Texas every time on the world market oil drops a dollar a barrel, it costs the State revenue to our treasury in Texas anywhere from $50 to $100 million.

The State of Texas is in its budget process right now. The legislature is in session and is facing a shortfall of a billion dollars. Pressures are on.

And that is why I reiterate the point. The mentality of State legislatures in this kind of situation is that if there is no Federal presence, that means it could not be priority. And I hate to have to say it that way, but it is the truth.

Mr. BLAZ. Thank you, sir. Your point is well taken.

Thank you very much, Mr. Chairman.

The CHAIRMAN. I wish to thank the members of this panel and all those who made a presentation this morning for a very interesting and informative morning. The committee learned a great deal.

I hope that we can take whatever we learned and put it into practice when the time comes. And the only time that that can be done is when the vote comes up with an appropriation that funds these necessary programs.

We have been talking a great deal about the fact that we need better methods of financing services for the blind.

But there is a great deal of need also for other social services that are being reduced in this country to a great extent.

As a member of the Appropriations Committee, I am also very much concerned about these cutbacks.

I don't know what is going to happen if we continue to reduce funds for education and for research, for services to the very citizens, to the blind, reductions also in even Medicare and Social Security.

These are things that only means that we as a society are going backward, and not forward.

So we will reassess the whole situation, and we hope we can come up with at least some partial solution.

You have made a tremendous contribution to the thinking process of this committee, and we hope to the Congress of the United States. And we thank you very much for your presence today.

The meeting is adjourned.

[Whereupon, at 11:55 a.m., the hearing was adjourned.]

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